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AMERICAN
JOURNAL OF INSANITY,
FOR JANUARY, 1879.

AN ABSTRACT OF THE LAWS OF THE
STATE OF NEW YORK,

IN REGARD TO THE COMMITMENT OF INSANE TO ASYLUMS, THEIR
DETENTION AND DISCHARGE, AND COMPARISON OF THE SAME,
WITH THE STATUTORY PROVISIONS OF ENGLAND.*

BY JOHN P. GRAY, M. D., LL. D.

Two broad considerations underlie this subject,—the welfare of the individual, and the safety of the public. The question of unnecessary interference with personal liberty, and the possibility of confounding sane and insane in the application of laws made to protect the latter, as well as society, are vital considerations. It is a fact and practically an axiom, that insanity implies or includes the necessity of special laws to meet the conditions which grow out of it, or in other words, to meet the symptoms and results of the disease itself. The laws upon the subject differ in various countries, as well as in the various States of our country. The objects everywhere are to determine what constitutes insanity, what degree or character of insanity produces loss of accountability for acts, or necessitates provision for the government of the person or property, and finally, confinement in hospitals, asylums, retreats, etc., for treatment and safety.

*Address as President of the Association of American Medical Editors, delivered at Buffalo, N. Y., June 3, 1878.

onic cells, in all parts, showed no decrease in number; were of normal size; and provided with processes of normal appearance.

In another part of his article the author discusses the relations of progressive muscular atrophy to some other forms of amyotrophies. He points out the following facts of general interest. The forms with which the disease might be confounded, are Duchenne's "*paralysie spinale antérieure subaiguë*," and certain deuteropathic amyotrophies, of a chronic nature. In this regard there is especially of importance, the absence of true paralytic symptoms, the absence of an "*atrophie en masse*" (Charcot), and the preservation of the electric irritability, and, at last, in a number of cases, the normal condition of the cord and of the roots and the trunks of the peripheral nerves. In the deuteropathic forms, the question arises whether we have to consider the spinal lesions as of primary or of secondary nature. In the first case, Charcot's theory could be upheld, if we agree, by sacrificing the clinical unity of the disease, to separate the form connected with spinal affection from the other. As long, however, as this action is not supported by the presence of clinical differences, the author thinks it unjustifiable, and much more reasonable, in accordance with Friedreich's views, to consider the spinal affection as of secondary nature.

Some light may also be thrown upon the question from the relation of progressive muscular atrophy to pseudo-hypertrophy or pseudo-hypertrophic paralysis. The close relationship of the two processes is very striking, and yet according to Charcot's own observations the peripheral nature of the latter would point to an essential dissimilarity between the two. This would not, however, be the case should we look upon the former also as of peripheral origin, with which spinal lesions, as secondary affections, may or may not be connected.

Notwithstanding, Prof. Lichtheim does not deny the trophic significance of the large ganglion cells of the anterior horns of the spinal cord and the influence of a primary affection of the same upon atrophy of the muscles connected with them. The characteristic symptoms of these affections are the following: Paralysis of the muscles, independent of their atrophic condition; "*atrophie en masse*" (Charcot), in opposition to the "*atrophie individuelle*" (Charcot) of progressive muscular paralysis. The author distinguishes the following primary spinal affections: (1) acute atrophic paralysis (infantile paralysis and its analogous affection in adults); (2) subacute atrophic spinal paralysis (Duchenne); (3) chronic atrophic spinal paralysis.

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UNITED STATES.

NEW HAMPSHIRE:

Thirty-Sixth Annual Report of the New Hampshire Asylum for the Insane, Concord: 1878. J. P. BANCROFT, M. D., Superintendent.

The number of patients at the beginning of the year was 280. There were admitted during the year 114 and there were discharged—recovered, 35; improved, 36; stationary, 30; and 17 died; leaving 276 at the end of the year.

The percentage of recoveries on admissions was 30.7. The percentage of total recoveries (1,519) upon total admissions (3,918) was 38.7.

An unusual number of the patients have this year needed special medical treatment. This is attributed, in part, to the ill-effect which the association of the worst class of the chronic insane has upon the hopeful class. It appears that the various counties take care of their chronic insane, except those cases that are most difficult to care for—the violent, destructive and uncleanly.

The Doctor is satisfied that amusements for patients may be carried to an extreme, and thinks the best plan is to have a moderate number of public exercises, and to have them of considerable merit.

A number of improvements are noted, among them a new boiler-room and engine, and reparation of the old Chandler wing.

Dr. Brown, for thirteen years assistant physician, was appointed superintendent of the Taunton Lunatic Hospital, and left to assume his new duties in March, 1878. Dr. Benner was promoted to the position of First Assistant, and Dr. Geo. W. Foster appointed Second Assistant.

CONNECTICUT:

Fifty-Fourth Annual Report of the Retreat for the Insane, Hartford: 1878. HENRY P. STEARNS, M. D., Superintendent.

The Institution contained 138 patients at the beginning of the year; 89 were admitted during the year and 95 discharged. Of the latter 34 were recovered, 8 much improved, 26 stationary and 15 died; leaving 132 at the close of the year.

The percentage of recoveries upon the number admitted was 38.2.

NEW YORK:

Thirty-Fifth Annual Report of the State Lunatic Asylum, Utica: 1877. JOHN P. GRAY, M. D., LL. D., Superintendent.

The number of patients at the commencement of the year was 566, and 460 were admitted during the year. There were discharged—recovered, 148; improved, 61; unimproved, 160; not insane, 15; and 60 died; leaving at the close of the year 582 patients in the Asylum.

The percentage of recoveries upon admissions was 33.26.

The Managers note the improvements that have been made during the year, among which are the completion of the renewal of wood-work of wards four, five and six, South, the painting of various wards, the enlargement of barns, construction of an ice-and-slaughter-house, of a wagon-house, tool-house and several reser-

voirs for water. They also make several recommendations as to repairs and improvements about the house, and that addition should be made to the farm land, by the purchase of a hundred acres. Since the report was presented to the Legislature, that body granted an appropriation to enable the Managers to proceed with the repairs and improvements of the South Side, and they are now prosecuting that work.

The Superintendent calls attention to the large number of admissions for the past ten years, an annual average of 434; and says that many have been refused admission on account of the overcrowded condition of the Asylum. He urges the importance of an early completion of the Institutions at Buffalo and Poughkeepsie; not only on account of the demand for more accommodation in the State, but for the securing of the more prompt and careful attention to recent cases, thus giving the greatest advantage in the way of cure. He refers to the influence of distance in preventing the utilization of institutions for the insane, the results of which were published by Dr. Edward Jarvis, in this JOURNAL (January, 1866). Those results showed that the proportion (to the average population) of patients sent to the Asylum, decreased steadily with the distance from the Asylum.

Since 1868, the number of chronic insane in the County House of Chautauqua County (remote from the Asylum) has increased 176 2-3 per cent; while the number of chronic insane in the County House of Oneida County (in which the Asylum is located) has increased only 59 per cent. Economy urges the greatest provision for the cure of the insane, for it is the chronic cases (who, as long as they live, are a constant expense), that chiefly constitute the great burden to the public treasury. The State has made extensive pro-

vision for the uncured, but "it has neglected the better and greater work of securing preventive measures against the increase of chronic insanity."

The Doctor refers to the expense and interest taken to do justice to a citizen charged with crime, and pertinently asks if the unfortunate from disease are to be treated with less consideration as to justice and humanity. The great majority of those who become insane come from the industrial and producing classes—it is rarely that a pauper in a poor-house becomes insane. It is important, therefore, that they be cured, for failure to secure this determines the loss to the community of a producer, and in very many instances the loss of a supporter to a family, and, as a result of this, the pauperization of many.

The policy of this State seems to be the erection of two classes of institutions—one for the treatment of the disease, and the other for the custody of those cases that become chronic; but whether this policy be adopted, or that of treating the acute and chronic cases in the same institution, "it is unquestionably necessary that the institutions should be located in the centers of population, and within a territorial limit that would allow of easy transportation." The system of building separate institutions for the chronic insane was adopted from the standpoint of economy—but it is also reasonable to assume that the expenses of institutions devoted solely to the treatment of acute cases, would be correspondingly increased. Thus far the policy of separation has been but imperfectly carried out—both chronic and acute cases being sent to Utica, Poughkeepsie and Middletown. Owing to the practical operation of the principle of distance in regard to the chronic insane, as well as to the idea of economy, various counties have undertaken to treat a large propor-

tion of their insane in their local institutions. The danger of this system is that, being so accessible, there is a temptation to commit to them the *curable* cases (especially such as are quiet), and so deprive them of curative treatment. This has been done in a number of counties, and there is a large increase in the number of chronic insane in the county-houses, within the past few years, due to this cause.

In the amount of labor performed by patients this year, there has been quite an increase over that of former years, which is shown in a table given of the work performed by the men for seventeen years. This increase has been due in part to the favorable season for out-door work. Most of those received have been overworked and many underfed, and to these any toil beyond moderate exercise would be detrimental. "The majority need rest and suitable occupation for the brain in the nature of diversion, rather than labor, of which latter they have had too much."

Pathological investigations have been continued by the Special Pathologist, Mr. Deecke. A very interesting result has been reached—the satisfactory sectionalizing of the whole brain. This permits the most perfect study of the anatomical relations of the various parts, and the most minute examination of abnormalities and lesions, and of the relation between them and symptomatology. The results of chemical analysis of the blood, referred to in the previous report, are given; and the Doctor remarks, among other things, upon the seeming disproportion between brain lesions and their symptoms, and upon the results of investigations into the functions of the brain and spinal cord. The history and post-mortem appearances are given in eighteen of the most interesting cases in which an autopsy was made.

Eighteenth Annual Report of the State Asylum for Insane Criminals, Auburn. CARLOS F. MACDONALD, M. D., Superintendent.

The number of patients in the Asylum, October 1, 1876, was 89. There were admitted during the year (chiefly from the State Prisons), 41; and there were discharged—recovered, 6; improved, 5; unimproved, 7; not insane, 7; and one died; leaving 104 at the close of the year.

The single death occurred in a case of advanced brain softening, and but a few days after his admission. This mortality is in striking contrast with the previous year in which nine deaths occurred. The superintendent attributes the change to an improved dietary, together with proper hygienic surroundings. In another portion of his report, Dr. MacDonald makes the following remarks on the subject of dietary, apparel and labor:

When patients are well fed and comfortably clad, they are much less turbulent, less destructive of clothing and furniture, and require less help to manage them; they are also less liable to intercurrent maladies, and, of course, escape the diseases and conditions incident to innutrition. Those patients who labor, or are otherwise pleasantly occupied, are improved both mentally and physically, sleep better at night and, by their labor, aid in diminishing the cost of their maintenance, while habits of industry and tidiness, and the cultivation of feelings of self-respect incite them to the preservation of their apparel, bedding, etc. Thus it would seem to be self-evident that, concomitant with the conditions mentioned, and as their inevitable result, we have a diminution of expense for wages, stimulants and other drugs, clothing, bedding, furniture and means of protection; and, in addition to this, we have a most enjoyable freedom, both night and day, from noise and disturbance, coupled with lessened cares and anxieties in the matter of administration.

Considerable improvements are mentioned, especially as to heating and ventilation; and an airing-court for men has been prepared.

Annual Report of the New York City Asylum for the Insane, Ward's Island: 1877. A. E. MACDONALD, M. D., Superintendent.

On the first of January, 1877, there were 681 patients in the Institution. During the year 366 were admitted and 128 re-admitted, giving a total under treatment of 1,175. There were discharged—recovered, 53; improved, 61; unimproved, 150; not insane, 9; and 126 died; so that 776 remained at the end of the year.

The percentage of recoveries upon admissions was 10.72.

The large number of re-admissions is chiefly made up of patients who had, from overcrowding, been transferred to other institutions, and, as the accommodations were increased, returned to the Asylum. Of those discharged, 135 were transferred to Randall's Island.

Dr. Macdonald reports continued improvement in the clothing, bedding, ward furniture, &c., and likewise in the appearance and healthfulness of several of the wards, owing to their having been renovated and painted. The exercising yards are very generally used and with much benefit to the patients. During the year a very interesting and important feature was inaugurated by the superintendent, viz: the holding of clinics in the Asylum for the benefit of students of medicine. This inauguration of clinical instruction in the asylums in this country, is no little credit to the Doctor, and we are glad that he has taken the initiative in so commendable and important an enterprise. During the month of June four clinics were held, admission being extended to the medical practitioners and students of the city, and the attendance averaged about eighty. "Over two hundred patients were brought before them without any accident or appreciable injurious effect."

"In accordance with the recommendations of former reports, a special pathologist has been appointed during the year, in the person of Dr. Andrew R. Robinson, a gentleman qualified by his studies, in this country and abroad, for the position."

The Institution has for years been overcrowded, and patients have had to be transferred to other receptacles. Toward the close of the year, the building which was formerly used for the emigrant insane, and which is located near the Asylum, was borrowed from the Department of Emigration. One hundred and fifty patients were transferred to this building (called the Annex), and seventy others transferred to it from the Homœopathic Hospital to which one hundred and fifty had been sent. The remaining eighty were soon to be transferred to the Annex, making three hundred in all. In addition to the relief thus afforded, and by the transfer of the large number to Randall's Island, work has been begun on a wing to the main structure which will increase the accommodations by about two hundred and twenty-five. The work is being done by inmates of the Asylum and work-house, but the Doctor thinks that by the time it is ready to occupy the number of inmates will have been augmented by the number it will accommodate, so that the institution will then be as crowded as it is at present, and therefore urges the commencement of a corresponding wing on the opposite side of the main building.

The Doctor has repeatedly made suggestions regarding the necessity for more and better attendants. The number was increased during the year from forty to forty-nine, but as the number of patients also increased, the relative proportion was not much altered. At the beginning of the year there was one attendant to seventeen patients—at the close of the year one to six-

teen, whereas there should be at least one to ten. A decided improvement, however, has been made in their quality.

Several changes have been made in the staff of assistant physicians, who receive no compensation, and are therefore migratory. There should be at least one assistant decently salaried, thus giving to his position such permanence, and to him such familiarity with detail, interest and sense of responsibility as would fit him to properly assume the duties of the superintendent during his occasional absences.

One Hundred and Eighth Annual Report of the Bloomingdale Asylum, New York City: 1877. CHAS. H. NICHOLS, M. D., Superintendent.

The number of patients in the Asylum, January 1, 1877, was 174. During the year 81 were admitted, and there were discharged—recovered, 18; improved, 34; not improved, 19; and 22 died; leaving 162 at the end of the year.

The percentage of recoveries upon admissions was 22.22.

This report is published in connection with the report of the New York Hospital of which the Asylum forms one department. Early in the year Dr. D. T. Brown, for twenty-five years in charge of the Asylum, resigned on account of impaired health, and Dr. C. H. Nichols, of the Government Hospital at Washington, was appointed to the place. Dr. Nichols took charge in May, 1877, and has commenced a series of improvements in the buildings and on the grounds. Twenty-five years ago Dr. Nichols resigned the superintendency of Bloomingdale to go to the charge of the Government Hospital, and now resigns that to return to Bloomingdale.

VIRGINIA:

Annual Report of the Virginia Eastern Lunatic Asylum, Williamsburg. H. B. BLACK, M. D., Superintendent.

There were 303 patients in the Asylum at the beginning of the year. During the year 75 were admitted, and there were discharged—recovered, 39; improved, 6; and 31 died; so that 302 remained at the close of the year.

Dr. Black, in his report, earnestly recommends the Legislature to act upon two suggestions which he makes:

The first is, that the General Assembly pass a bill authorizing superintendents to grant "leaves of absence" or "furloughs" for a limited period—say not to exceed sixty days—to such patients as in their judgment could be confided to their friends willing to take them, and with authority to extend the same from time to time as might be found expedient; provided that all expenses of transportation, both from and to the Asylum, be paid by the friends of the patients, unless otherwise ordered by the Executive Committee.

The second is for the legislature to pass a bill authorizing the board of directors, through the Executive Committee, to provide homes whenever practicable, with the relations and friends, or such other suitable persons as may be willing to take them, for such of the chronic insane as the Superintendent may recommend as being harmless and incurable, and to pay for their care and maintenance such compensation as may be agreed upon, not to exceed, say \$150 per annum.

Undoubtedly it is good policy to transfer to their families all such cases as will not be further benefitted by remaining in an asylum, and who could be taken care of at home. The point that the Doctor makes is a good one, that, where families are unable to take care of them, pecuniarily, the public grant the necessary aid.

IOWA:

Ninth Biennial Report of the Iowa Hospital for the Insane, Mount Pleasant: 1876 and 1877. MARK RANNEY, M. D., Superintendent.

At the beginning of the period there were 551 patients in the Asylum. There were admitted during the period 556 and discharged—recovered, 155; improved, 75; stationary, 139; one was not insane, and 129 died; leaving 608 in the Asylum at the close of the period.

The percentage of recoveries upon admissions was 27.8.

On the 18th of April the engine-and-boiler-house was destroyed by fire, which fortunately was prevented spreading to the wards. A new building was immediately put up, which not only supplies the place of the old one, which included wash-room, laundry, drying-room, fan-room, coal-room, &c., but gives in addition a mortuary, pathological-room, work-room, and a clock tower visible from all parts of the house, and also a bakery.

The Institution is greatly overcrowded. Having been constructed to accommodate three hundred, it has had to shelter at times twice that number. The difficulty of such an undertaking can only be appreciated by those who have had a similar experience.

In 1865 this hospital was considered complete, with room for three hundred patients, and toward the close of that year its beds were all occupied. Since that time, while the population of the State has increased by about seven hundred thousand—has about doubled—and the number of the insane has increased by about seven hundred, the increase of hospital accommodation has been only about two hundred and seventy-five beds. The result has been an irresistible pressure for room that has crowded the two hospitals with accommodations for only five hundred and seventy-five, with over nine hundred patients, while some five hundred more are scattered over the State in jails or poor-houses, or in families, some of whom are illy able to bear the burden of their care.

The Doctor therefore urges, and with the greatest reason, that steps be taken, at once, to complete the new Institution at Independence, and to enlarge the one under his care.

"For the fifth time" Dr. Ranney protests against the admixture of the convict insane with ordinary cases of insanity, and recommends, either that a ward at the penitentiary be set apart for them, or that they have a separate building provided for them in connection with the Asylum. From their character and habits he does not deem them fit to mingle with decent people. As to the association in the same institution of both the chronic and acute classes, the Doctor expresses himself favorably.

The incurable insane may be maintained, perhaps, for less than is a necessary outlay to promote recovery during that period when, by judicious treatment, it can be brought about; but I think it is yet to be shown that the treatment of the curable in one building, and caring for incurable in another, will lessen the cost of managing both classes together. Food, and raiment, and warmth, and pure air are as essential for the incurable as the curable, and must be as abundant, and can cost but little less. They may need less medicine and less personal attendance, but if they need less, those in the acute stage, if treated separately, will need more.

If it is objected that the presence of the incurable insane in a hospital engaged in the treatment of curable insanity is injurious to the latter, I have to answer, out of my own experience, that, with certain exceptions, I do not know it is so. Indeed, I am not certain but the effect is just the reverse. No inconsiderable portion of the incurable insane are quite tranquil, well disposed, and more or less attached to their home and the hospital—far more so than those in the acute stage of the disorder. The presence of this class, at least, is seldom injurious, and has often been in my experience, beneficial.

The importance of early treatment is dwelt upon. "Insanity," he says, "is a highly curable disorder, in its early stages—in its first beginning—but its curability

rapidly diminishes with lapse of time." Dr. Ranney is fully convinced of the importance of more complete pathological investigation, and asks the Legislature for a sufficient sum to establish such a department in the Institution at Mount Pleasant.

WASHINGTON TERRITORY:

Report of the Hospital for the Insane of the Territory of Washington, Olympia: 1877. RUFUS WILLARD, M. D., Superintendent.

The number of patients in the Hospital, August 16, 1876, was 61. During the year 32 were admitted, and there were discharged—cured, 21; improved, 1; one eloped, and one died; leaving 68 in the Asylum at the end of the year.

This is a new Institution, and evidently its Superintendent and Managers are laboring under many disadvantages—having wooden structures, with so few wards as not to allow of proper classification. During the year Dr. Sparling, the first Superintendent, was removed by the Board on charges preferred, and Dr. Willard succeeded to that office in June, 1877.

The percentage of recoveries on admissions (65.62) is certainly a good showing.

CANADA.

ONTARIO:

Report of the Asylum for the Insane, Toronto. DANIEL CLARK, M. D., Superintendent.

There were 631 patients in the Asylum at the beginning of the year. During the year 232 were admitted, and there were discharged—cured, 75; improved, 22; unimproved, 15; eloped, 1; transferred, 21; on probation, 4; and 58 died.

The percentage of recoveries upon admissions was 32.32.

This report deals with several subjects of great interest, chiefly, that which has recently been generally discussed within and without the specialty. Speaking of restraint, and quoting the conclusions of Dr. Grisom, in his paper read before the Association at St. Louis, and published in this JOURNAL, he concludes:

If all restraints, whether medical, personal, or mechanical, could be dispensed with, none would rejoice more than those who feel it incumbent upon them to resort to them, but the type of manner must change very much on this continent before it can be judicious, safe, or therapeutically correct to do so under existing circumstances.

The Doctor also discusses self-abuse as a cause of insanity. Our experience would lead us to doubt the great importance as a factor, which the Doctor would give to it.

Dr. Clark has made records of pulse and temperature in several cases of dementia, paresis and phthisis, with the result, that "so far, in our investigations here, neither pulse nor thermometric tests show indications of the genus or species of insanity, or its ally, called latent phthisis." He also gives several cases of the use of Nitrite of Amyl in epilepsy, and says, that "the twenty-five or more persons who have taken it for a longer or a shorter time, have, almost without exception, been benefitted by it."

Report of the Asylum for the Insane, London. R. M. BUCKE, M. D., Superintendent.

The year began with 583 patients. During the year 129 were admitted, and there were discharged—recovered, 61; improved, 11; unimproved, 2; 2 eloped and 27 died.

The percentage of recoveries upon admissions was 47.28.

Dr. Bucke assumed charge of the Asylum in February, 1877, soon after the death of Dr. Landor, his predecessor.

The Doctor speaks of improvements that have been made, and then touches upon the subject of restraint:

In the report of the late Dr. Landor, for 1871, he claimed that this was a non-restraint asylum. When the Institution came into my hands early in this year, there was as much restraint used here as at any of the restraint asylums that I have visited in this country or in the States. As I can not suppose any insincerity on the part of Dr. Landor, when he made his report in 1871, I must suppose that he, upon enlarged experience and mature consideration, changed his mind upon this point, and became towards the end of his life a believer in mechanical restraint. I can not see that in any of his reports he declares this change of opinion and practice to the world. For my own part, I am persuaded that the use of mechanical restraint variously applied to meet the requirements of particular cases is the most useful and least disagreeable, the cheapest and least injurious, of any form of restraint that can be used. And as for non-restraint, I do not believe it can be or ever was practiced; it would be a worse cruelty to many patients than the old chains and straight waistcoats of Bedlam. No form of restraint has been added to those before used at this Asylum since I took charge of it, except six crib-beds and six restraint chairs. The crib-beds I look upon as the most absolutely unobjectionable of all forms of restraint. They permit every movement that a patient ought in his own interest to make. They allow him to lie in any position, to turn from side to side, to draw up his legs or stretch them out; they are only a restraint inasmuch as they prevent the patient from getting out of bed.

He then relates a case which illustrates the utility of the crib-bed, and its advantage over the tying-in-bed or holding-in-bed process.

The Doctor also devotes some remarks to the subject more extensively considered by Dr. Clark, and more nearly in accordance with our own views as to the relation it holds to insanity. Speaking of self-abuse, he says:

This habit has often been looked upon as a prominent cause of insanity, and most writers consider it to be a cause in some instances. Whether it is ever the sole cause of insanity I very much doubt. But I am satisfied that along with other causes, such as hereditary predisposition, this habit may materially assist in bringing on the attack. In many other instances the attack of insanity, having been brought on by entirely different causes, it is nevertheless aggravated by this habit, which in this case may have been contracted before the onset of the mental disease, or not until after the moral sense of the patient was weakened or destroyed by his or her malady. In still other cases, the habit is a symptom of the disease, and nothing more. It is simply a result of the cerebral or ganglionic irritation which is a part of the patient's diseased state.

NOVA SCOTIA:

Report of the Nova Scotia Hospital for the Insane, Halifax:
1877. JAMES R. DEWOLF, M. D., Superintendent.

There were 337 patients in the Hospital at the beginning of the year. During the year 94 were admitted, and there were discharged—recovered, 48; relieved, 7; and 25 died. This shows 51 per cent of recoveries on admissions. The percentage of recoveries on the entire number (1,275) of admissions since the opening of the Institution, was 42.75.

Since the date of this report, Dr. DeWolf has been superseded by Dr. A. P. Reed. Among various subjects which Dr. DeWolf discusses, is that of remuneration of industrious patients which he advocates, and cites the favorable experience of Dr. Orange, of the Broadmoor Criminal Lunatic Asylum. Speaking of lunar influence upon the insane, he says that he found many patients restless and noisy on moonlight nights, but believes this to be due simply to the influence of the light in keeping them awake, just as any artificial light would effect.

NEW BRUNSWICK:

Report of the Provincial Lunatic Asylum, St. John. JAMES T. STEEVES, M. D., Superintendent.

The number of patients at the beginning of the year was 276. There were admitted during the year 88, and discharged—recovered, 38; improved, 7; unimproved, 5; eloped, 2; and 31 died.

The percentage of recoveries on admissions was 43.1. The percentage of recoveries on the entire number, (2,875) of admissions since the opening of the Institution was 42.7.

PRINCE EDWARD ISLAND:

Annual Report of the Lunatic Asylum, Charlottetown: 1877. EDWARD S. BLANCHARD, M. D., Superintendent.

There were 66 patients in the Asylum at the beginning of the year; 35 were admitted during the year, and there were discharged—recovered, 8; relieved, 5; not improved, 4; and 6 died.

The percentage of recoveries on admissions was 22.9.

The Superintendent tells us that plans have been made, and contracts let for a new hospital, which, when finished, will compare favorably with any in America, not only in the beauty of its surroundings, but what is far more important, in the facilities which it will afford for the most enlightened curative treatment of all the insane within her (Prince Edward Island's) borders.

GREAT BRITAIN.

ENGLAND:

Twenty-Seventh Annual Report of the Asylum for the Insane Poor of the County of Wilts. J. WILKIE BURMAN, M. D., Superintendent.

In the Asylum, January 1, 1877, there were 487 patients, and during the year 161 were admitted. There

were discharged—recovered, 55; relieved, 4; not improved, 10; not insane, 1; and 56 died.

The percentage of recoveries on admissions was 34.1. The weekly cost, per capita, was 9s. 2 3-4d.

Thirteenth Annual Report of the Staffordshire Asylum, Lichfield: 1877. R. A. DAVIS, M. D., Superintendent.

There were in the Asylum at the beginning of the year 498 patients. During the year 133 were admitted, and there were discharged—recovered, 26; relieved, 27; transferred, 6; not insane, 1; and 46 died.

The percentage of recoveries on admissions was 19.54. The weekly cost, per capita, was 9s. 4 1-2d.

Report of the South Yorkshire Pauper Lunatic Asylum. SAMUEL MITCHELL, M. D., Superintendent.

At the beginning of the year the Asylum contained 789 patients; 381 were admitted during the year, and there were discharged—recovered, 134; relieved, 65; not improved 3; and 105 died.

The percentage of recoveries on admissions was 35.1. The weekly cost, per capita, was 9s. 5 3-4d.

Twentieth Annual Report of the Cambridgeshire, Isle of Ely, and Borough of Cambridge Pauper Lunatic Asylum. GEO. MACKENZIE BACON, M. D., Superintendent.

There were in the Asylum at the beginning of the year 308 patients; 92 were admitted during the year, and there were discharged—recovered, 30; relieved, 6; not improved, 3; and 48 died.

The percentage of recoveries on admissions was 35.8. The average weekly cost, per capita, was 10s. 11 1-2d.

Report of the County Lunatic Asylum at Prestwich. H. ROOKE LEY, Superintendent.

There were in the Asylum at the beginning of the year, 1,128 patients; 432 were admitted during the

year, and there were discharged—recovered, 214; relieved, 91; and 95 died.

The percentage of recoveries on admissions was 49.53. The weekly cost, per capita, was 9s. 1d.

Regarding the importance of early treatment, Dr. Ley remarks:

Of the 432 cases received during the past year, 198 were patients in whom the disease had existed previous to their being placed under treatment for a period exceeding six months, 234 were cases in which it had existed for a much shorter period. Of the former group only 48 or about 24 per cent were deemed curable, and of these 26 have recovered, 14 are convalescing, and the others remain with little improvement. But of the latter group 178 were on their admission regarded as curable, and of these 116 have been discharged, and the remainder, with few exceptions, are on a fair way towards recovery. *These facts again testify in the most striking manner the paramount advantage of early treatment.*

Twenty-Second Annual Report of the Lunatic Hospital for the County and Town of Nottingham—The Coppice, near Nottingham: 1877. W. B. TATE, M. D., Medical Superintendent.

The number of patients in the Hospital, January 1, 1877, was 64; admitted during the year, 19; and there were discharged—recovered, 7; relieved, 2; not improved, 2; and 5 died.

The percentage of recoveries on admissions was 26.3.

This is an Asylum "into which patients are received, who, not being paupers, are unable to pay the whole expense of their care and maintenance," and it is supported by voluntary contributions. Their rates vary from 7s. to 40s. per week. The Doctor asserts that "no patient has been restrained or secluded. Indeed restraint has never been employed, and seclusion only once since the opening of the Hospital nearly nineteen years ago," and "no suicide or serious accident has occurred." It must be remembered that the Institution is not large,

and only receives about twenty patients a year. From the fine lithograph that forms the frontispiece to the report, we infer that the building is a substantial and beautiful structure.

Report of the County Lunatic Asylum at Lancaster: 1877. Dr. DAVID M. CASSIDY, Medical Superintendent.

The number of patients at the beginning of the year was 984. During the year 327 were admitted, and there were discharged—recovered, 119; relieved, 70; not improved, 5; and 100 died.

The percentage of recoveries upon admissions was 36.39. The average cost per head, per week, was 9s. 1 3-4d.

Dr. Cassidy, who was formerly Deputy Superintendent at Broadmoor Criminal Asylum, has here given us an interesting report.

Among the admissions were 52 cases of epilepsy, and 40 cases of general paralysis, and there were 27 congenital imbeciles or idiots. The maximum number that could be considered curable was 159, and 75 per cent of this number recovered. The Doctor deprecates the practice of relieving officers in taking lunatics to the work-houses before removing them to an asylum, and keeping them there too long. Only 26 per cent of the admissions were sent within three months of the commencement of the attack. He urges the importance of early treatment. As to the separation of chronic from recent cases, he seems to share the opinion of the Earl of Shaftesbury, whom he quotes, "the one should be within reach of the other, and possibly, even, under the same roof," and adds, "by proximity of the two departments, all share alike in the resources of the Asylum, as needed; transference from one part to another, as patients' condition varies, is facilitated, and the value of the

permanent residents, as workers, is not lost." As a consequence of the large number of epileptics in the Institution, there is this remarkable report—four deaths from suffocation in epileptic fits—three of them were by turning upon the face in bed, and the other by choking with pieces of blanket which he had in his mouth. "Most of the male epileptics were removed to the red building, where accommodations were provided for sixty-four in the large dormitory," where they were under night supervision. Two of the deaths referred to, occurred in this large dormitory, "in spite of these precautions, and served to show the dangers to which this class of patients is liable, and the necessity of the greatest care and watchfulness over them. * * The number of epileptics is 157, of whom 95 are men, and 62 women, and observations made upon them during the past few weeks, have demonstrated that 41 of the men, and 15 of the women, occasionally or frequently turn upon their faces when they have fits in bed."

Post-mortem examinations were made in 91 of the 100 cases of death. "This procedure is of the greatest value and interest, and I think it ought to be a sequence of most deaths in lunatic asylums." The Commissioners refer, in their report, to a few cases of typhoid fever that occurred the preceding year, due to defective kitchen drainage. Three cases were servants, two of whom died. Evidently the drainage was not properly attended to, for the Doctor reports in the following year twenty-one cases and four deaths, from the same trouble. Seven fractures and dislocations are reported. The Commissioners say "the cases of bruises and black eyes which appear to be very carefully recorded in the medical journal, are unusually numerous, and we ourselves noticed a considerable number of such injuries during our visit."

Eighth Annual Report of the Lunatic Asylum for the Borough of Leicester, Humberstone: 1877. J. E. M. FINCH, M. D., Medical Superintendent.

The number of patients in the Institution at the beginning of the year was 315. During the year 114 were admitted, and there were discharged—recovered, 44; relieved, 6; not improved, 2; not insane, 2; and 39 died.

The percentage of recoveries upon admissions was 38.59. The weekly cost per capita was 12s. 2 7.8d.

There are evidently a great many epileptics in the Institution, as large dormitories for them, and night supervision are spoken of. This separation of epileptics from the ordinary insane is very desirable. They ought, indeed, to be in separate institutions. The Doctor tells us that during the year 16,419 epileptic fits were recorded. Two inquests were held—one on a case of paresis, who was choked by a piece of meat getting into his larynx, and the other, an old man who fell in trying to get out of bed, and broke three ribs. Two other accidents occurred, which did not prove fatal—a dislocated shoulder in one case, and in the other, a fracture of base of skull, from a fall from a ladder, probably with suicidal intent.

Seventh Annual Report of the Cheshire County Asylum, Parkside, near Macclesfield: 1877. P. MAURY DEAS, M. B., London, Medical Superintendent.

The year began with 534 patients, and 184 were admitted and 177 discharged. Of those discharged—62 were recovered, 19 relieved, 39 not improved, 3 not insane, and 54 died.

The percentage of recoveries upon admissions was 33.7. The average weekly cost, per capita, was 11s. 1 1.2d.

For several years the Institution has been patronized by private patients. The Doctor thinks this should be encouraged, and recommends "that, where practicable, there should be a department for private patients, at low rates of board only, in connection with our county asylums." The endowed institutions which benefit the middle classes, by assuming a portion of the expense of maintenance, are too limited to meet the demands upon them. He says: "A considerable number of our county patients are only pauper patients in name, their friends paying the whole cost of their maintenance in the Asylum through the boards of guardians," and "it has always seemed to me a great hardship that the stigma of pauper should be attached to such cases." This want is met very generally in the United States by the order of indigence, granted by the county judge.

"Intemperance plays a sadly prominent part in the production of insanity among the men. In 16 out of the 58 men it appeared to have had a decided share in producing the insanity. Such a connection could only be traced in one woman."

Three cases were discharged this year as "not insane," and since the opening of the Institution there have been fourteen such cases; and the Doctor adds, "I do not think in any of these cases (except perhaps one) was there the least evidence of want of bonâ fides, or of possible wrong motive on the part of any concerned in the sending of the patient. The most that could be said would be that perhaps a little more patience, and a little longer delay would have revealed the true nature of the case. * * But this much may, I think, be confidently said, that the independent, unbiased judgment of the medical officer of the Asylum is, in itself, a sufficient safeguard against the illegal de-

tention of patients who may have, from *any* cause, been sent to the Asylum unnecessarily."

One case of suicide occurred in a man who had been gone from the Asylum a fortnight on trial.

"Two attendants were discharged for harshness to patients, three for intemperance, and one for dishonorable conduct."

Eighteenth Annual Report of the Lunatic Asylum for the Counties of Bedford, Hertford and Huntingdon, called the "Three Counties' Asylum," near Arlesey: 1877. Dr. EDWARD SWAIN, Medical Superintendent.

There were 710 patients in the Asylum at the beginning of the year, and 148 were admitted during the year. There were discharged—recovered, 60; relieved, 5; not improved, 45; and 67 died.

The percentage of recoveries on admissions was 40.54. The average weekly cost of maintenance, per capita, was 9s. 8d.

"Neither mechanical restraint nor seclusion has been employed. The treatment of the patients has consisted principally in improving their health by good food, producing sleep in the sleepless (a large contingent among the newly admitted), and trying to induce them to forget their troubles by employment, amusement, etc. For producing sleep, moderate doses of chloral or hyoseyamus, with bromide of potassium, are found the most efficacious measures we possess."

Thirty-Second Annual Report of the Devon Lunatic Asylum, Exeter: 1877. G. SYMES SAUNDERS, M. B., Medical Superintendent.

There were 724 patients in the Asylum, January 1, 1877, and during the year 156 were admitted. There were discharged—recovered, 65; relieved, 13; not improved, 4; certificates being informal, 1; and 50 died.

The percentage of recoveries upon admissions was 41.73. The average cost per head, per week, was 9s. 3 1-2d.

Annual Report of the County of Warwick Pauper Lunatic Asylum, Warwick: 1877. Dr. W. H. PARSEY, Medical Superintendent.

The number of patients in the Asylum on the 1st of January was 605, and 147 were admitted during the year. There were discharged—recovered, 37; relieved, 8; not improved, 1; and 51 died.

The percentage of recoveries upon admissions was 25.1. The weekly cost per capita was 9s. 4 5-8d.

The district which patronizes this Asylum includes the famous Stratford-on-Avon, to which we find forty of the lunatics in the Institution credited. The Doctor makes some very good suggestions regarding the apparent increase of insanity. The Asylum for the County of Warwick has an accommodation for a proportion of one to four hundred and fifty of the population, and yet measures must immediately be taken to increase the accommodation.

The aggregation of chronic lunatics, however, is no criterion in forming a judgment in this matter. The best basis would be a comparison of the recent cases of one year with those of another. The recent cases (under one year) admitted during the past year are several less than the average for the past ten years. He thinks the increase of admissions among the pauper insane, during the past few years, is not so much due to an absolute increased proclivity to insanity as to, *e. g.*, "the more extended popular recognition of the disease in its less pronounced forms; the greater confidence among all classes of the community and the advantage of care and treatment in public asylums; the readiness

with which the insane members of the classes above the actual poor are made paupers, that they may become participators in these advantages, the whole or a greater portion of their expenses being refunded to the Unions by their relatives; the willingness of parochial authorities, by sanctioning such arrangements, to partially meet one of the great social wants of the day, a proper asylum provision within their means for the insane members of the lower and middle classes; the diffusion of the cost of maintenance of all insane paupers over much more extended areas; and, lastly, the government grant-in-aid for all those whose friends are unable to contribute so much as four shillings a week toward their maintenance in an asylum."

The Doctor has just set apart two large dormitories, each containing forty beds, for epileptics. In each dormitory an attendant sits all night to prevent catastrophe from fits. He reports an epileptic who "broke his leg for the third time within a year and a half, each time by twisting it under him while falling in a fit. Another male epileptic broke two ribs by falling in a fit against the edge of a bench; and an old woman got the neck of her thigh bone broken by being pushed down by a fellow patient."

Thirteenth Annual Report of the Somerset County Pauper Lunatic Asylum, Wells: 1877. C. W. CARTER MADDEN-MEDLICOTT, M. D., Medical Superintendent.

The number of patients in the Asylum, January 1, 1877, was 640, and 192 were admitted during the year. There were discharged—recovered, 58; relieved, 15; not improved, 7; and 67 died.

The percentage of recoveries on admissions was 29.9.

The Doctor speaks of a middle-class asylum for the county as an "imperative necessity."

During the past year the committee of the Asylum decided that criminal lunatics should not be admitted to the Asylum. "This is a matter for congratulation, for in most cases they are old offenders, and have led very vagrant lives, residing alternately in either the work-house, prison, and even the Asylum itself; and their mingling with the patients had a very prejudicial and contaminating effect."

The appendix to the report contains the rules for the government of the Institution.

Twenty-sixth Report of the Derbyshire County Lunatic Asylum, Mickleover, Derby: 1877. J. MURRAY LINDSAY, M. D., Medical Superintendent.

January 1, 1877, the Asylum contained 419 patients; and during the year 175 were admitted, and there were discharged—recovered, 64; relieved, 11; not improved, 31; and 60 died.

The percentage of recoveries upon admissions was 36.5.

The average weekly cost per capita was 10s. 10 1-2d.

Dr. Lindsay seems to favor the idea of having a separate County Asylum for private patients, many of whom, he says, are now sent to Mickleover as paupers, though their friends pay the parish the expense of their maintenance. Many would be willing to pay more than the pauper rates if separate provision were made for them. "The question of the mixed system of accommodating pauper and private patients in the same building, was frequently referred to with disapproval in the evidence of the Select Committee of the House of Commons on Lunacy Law, ordered to be printed 30th July last; and a general and strong opinion was expressed by the Lunacy Commissioners and other authorities in favor of having these two classes, if

private patients are to be received in county asylums, in separate buildings under the same management, as at the Cornwall County Asylum, where the system is in satisfactory and successful operation."

Speaking of inebriates, the Doctor remarks: "For the proper control and treatment of dipsomaniacs, insane drinkers, habitual inebriates, or whatever term may be applied to this class, there is a growing and strong conviction on the part of the public and of the medical profession that some effective legislative provision is necessary, by the establishment of retreats, inebriate asylums or other special institutions for the enforced and prolonged detention of this class, so dangerous to themselves and the cause of so much misery and trouble to all connected with them. In this respect Colonial legislation is in advance of British. In Victoria an act has been in successful operation for the last five years for the care and treatment of habitual inebriates by granting licenses to retreats or inebriate asylums."

After speaking of the high death-rate, and attributing it to an unusual share of the worst forms of the disease, as, for instance, general paralysis, he says of that disease: "In some counties, as in Derbyshire, it is more prevalent than in others, whilst in Irish Asylums this disease is comparatively rare, almost unknown. By a process more ingenious than scientific, an able and distinguished writer in Ireland endeavored to show that the much greater prevalence of general paralysis in England, was due to the use of beer, whilst the comparative immunity of the Irish people, was due to their preference for good whiskey. This is a point well worthy the attention of all temperance advocates."

WALES:

Twenty-Fifth Annual Report of the Joint Lunatic Asylum for the Counties of Monmouth, Brecon and Radnor, Abergavenny:
1877. D. M. McCULLOUGH, M. D., Medical Superintendent.

There were 519 patients in the Asylum, January 1, 1877, and during the year 110 were admitted. There were discharged—recovered, 39; relieved, 10; not improved, 1; transferred to Hereford, 20; and 47 died.

The percentage of recoveries upon admissions was 35.4. The average weekly cost per capita was 9s. 8d.

Dr. McCullough reports a marked falling off in admissions as compared with the preceding five years, which he attributes, in part, to the exhaustion of chronic and congenital cases transferred from work-houses, under the influence of the government allowance of 4s. per week; and in part to the extensive migration of the young of both sexes from the district, owing to the depressed condition of the iron and coal trades. The following remarks of the Doctor, concerning a symptom of general paresis, are interesting:

In my report for 1873, I called attention to the fact that insanity is by no means unfrequently punished as crime, and pointed out that stealing is a common symptom of a peculiar form of organic disease of the brain which always terminates in death. During the past year two patients were admitted, laboring under this disease—paralysis of the insane—who had been convicted of larceny, and who came to the Asylum in a debilitated state, as a result of prison diet and discipline. Inquiry into the history of these cases left no doubt that the disease existed at the time the articles were stolen, and in one of the cases certainly for months before. It is well for magistrates to bear in mind that such cases occur, though I can understand their feeling a difficulty in discriminating them. In general it will be found that a change of character and habits has preceded the stealing, and that the stealing is usually irrational, and without any regard to the probability of discovery.

SCOTLAND:

Annual Report of the Royal Edinburgh Asylum for the Insane, Morningside: 1877. T. S. CLOUSTON, M. D., F. R. C. P., Medical Superintendent.

The number of patients in the Asylum and on probation, January 1, 1877, was 734. During the year 342 were admitted, and there were discharged—recovered, 170; relieved, 88; not improved, 20; and 63 died.

The percentage of recoveries upon admissions was 49.7

Dr. Clouston calls attention to the increase of pauper lunatics, but assures the public that this "is not due to any great increase of lunacy." He repeats some of his suggestions upon this subject in his last report (see review in this JOURNAL, October, 1877), especially as to the influence of "the premium of four shillings a week from the imperial exchequer given for each pauper who is a lunatic."

Most fortunately, the increase in the total number of pauper patients chargeable at the end of each year bears no proportion to the growing increase in the admissions, for they have only risen from 460, at the end of 1873, to 489 at the end of this year. While, in fact, the admissions have risen 30 per cent in the last four years, the total numbers chargeable have only risen 6 per cent. This curious fact is owing to several causes, the chief of which are, that the cases are now sent in at an earlier and more curable stage, and slighter and more transient cases are sent here, so that, as a matter of fact, a higher percentage now recover. The second circumstance which produces this desirable result is, that the Scotch Lunacy Statutes make easy and abundant provision for the discharge of patients from Asylums, both when they are recovered, and also when they are so far relieved of the worst symptoms of their malady, that they are harmless and manageable. In this respect it is in marked contrast to the English law.

The Doctor further contrasts the English and Scotch Lunacy Laws, and refers to several points brought out before the Parliament Committee last year.

There is no doubt that patients are now sent into Asylums sooner than formerly. About 40 per cent of the admissions were sent here within the first month of their being attacked. In the case of many private patients, where medical and ordinary attendance can be secured at home, it is one of the most difficult of all medical questions to decide whether a case should be removed to an asylum in the first month of the disease or not. But among the poor, where no such attendance can be got, and the surroundings are all against recovery, there is no doubt that early treatment in an asylum is the best thing for the patient, and the sooner that treatment can be applied the better.

In speaking of causation he says, "the over-indulgence in drink, as usual, brought on their disease in more cases than any other single cause. The griefs, despair, excitements, domestic trials, frights, religious emotions, and disappointments in love of the community, only overturned the reason of 64 patients to the extent that they needed to come here, while drink alone sent us 53 victims." The mortality of the year has been very low—and especially so among the men. This the Doctor attributes "in some measure to the improved ventilation, lighting and sanitation which are the result of the radical alterations in the structure of the whole department and its work-shops recently effected, as well as to the increased means of working and exercising in the open-air provided for the male patients. No doubt the abolition of the old airing-courts, the patients going out into the open grounds instead, has had something to do with it; and the introduction of far more work in the garden of a simple kind, such as digging and wheelbarrow work, suitable for those whose minds are too much affected to do work requiring mental application or effort."

The Institution appears to be prosperous.

The greatest and most enduring of all the events which have happened since I wrote my last report, has been the purchase of

the Craig House estate. To have acquired 50 acres of additional land was of immense importance, but to have got it contiguous, to have it magnificently wooded with old timber, so secluded and yet with such extensive views, so airy and yet so sheltered, and pronounced by the highest sanitary authorities in the country, in Sir Robert Christison's report from the Medical Board, to be most salubrious, is, from a medical point of view, of incalculable importance to us.

"Morningside," with its East House and West House and Craig House and Cottages, is evidently quite a feature of Scotland's ancient Capital.

IRELAND :

Report of the Richmond District Lunatic Asylum, Dublin : 1877.
Dr. JOSEPH LALOR, Medical Superintendent.

At the beginning of the year there were 1,053 patients in the Asylum. During the year 432 were admitted, and there were discharged—recovered, 193; improved, 51; unimproved, 5; and 174 died.

The percentage of recoveries on admissions was 44.6. The average cost of each patient for the year was £25 18s. 1d.

Dr. Lalor's report is devoted principally to remarks upon the schools in that Institution, which he inaugurated there twenty years ago. From the very large proportion of uneducated persons admitted to the Asylum (as we see from Table viii), it would seem desirable that an attempt be made, even in the Asylum, to give them the *rudiments* of education. In our own country there are so few (and they chiefly foreigners), who do not possess at least that *fundamental* knowledge which, from the Doctor's long experience, seems to be the practical limit of asylum teaching, that such a department would not only be superfluous, but out of place. In the few instances, here, where years ago schools were introduced,

they have been discontinued, and we trust there may never exist, in our land, such a popular ignorance as would render them necessary.

Annual Report of the District Lunatic Asylum, Clonmel, Tipperary: 1877. Dr. W. H. GARNER, Superintendent.

The number of patients in the Asylum, December 31, 1876, was 367. During the year 79 were admitted, and there were discharged—recovered, 37; improved, 9; escaped, 1; and 24 died.

The percentage of recoveries on admissions was 46.8.

A case of suicide is reported, effected by "throwing herself out of a window of the day-hall." It occurs to us that this may have some relation to that much talked of absence of "bolts and bars" in the British Asylums, although the superintendent says he "can not acquit the attendants in charge of all blame."

The Asylum was opened in 1834, with accommodation for 60, and has been at various times increased so that now there are beds for 385. There is a small margin now, but Dr. Garner recommends that the governors consider the matter of making further additions to its capacity. Other recommendations are also made—as to better provision in the way of kitchens, laundries, and especially chapel accommodation. The proportion of Roman Catholics to Protestants is as 12 to 1. The cost per head for the year is £29 17s. 9d., or about \$150.

Annual Report of the Cork District Lunatic Asylum, Cork: 1877. JAMES ALEX. EAMES, M. D., Superintendent.

The number of patients in the Asylum, December 31, 1876, was 742. During the year 219 were admitted, and there were discharged—recovered, 80; improved, 29; unimproved, 1; and 105 died.

The percentage of recoveries on admissions was 36.52. The total expenditure, per patient, for the year was £25 2s. 3d.

Forty-Eighth Report of the Belfast District Hospital for the Insane, Belfast: 1877. ALEX. STEWART MERRICK, M. D., Superintendent.

The number of patients remaining in the Hospital, December 31, 1876, was 424. During the year 169 were admitted, and there were discharged—recovered, 81; improved, 37; unimproved, 2; and 34 died.

The percentage of recoveries on admissions was 47.9. The percentage of total recoveries (3,117) on total admissions (5,704), during 48 years, 7 months, was 54.6. The average cost, per head, for the year was £24 18s. 4d.

Report of the Donegal District Lunatic Asylum, Letterkenny: 1877. Dr. JOSEPH PETT, Medical Superintendent.

The year began with 287 patients; 103 were admitted during the year, and there were discharged—recovered, 35; relieved, 19; not improved, 1; escaped, 1; and 26 died.

The percentage of recoveries on admissions was 33.9. The total expenditure, per head, for the year was £23 11s.

REVIEWS OF BOOKS, REPORTS, &c.

Commentaries on the Lunacy Laws of New York, and on the Judicial Aspects of Insanity at Common Law and in Equity, including Procedure, as expounded in England and the United States. By JOHN ORDRONAU, State Commissioner in Lunacy, Professor of Medical Jurisprudence in the Law School of Columbia College, New York, and Author of the "Jurisprudence of Medicine." Albany: John D. Parsons, Jr., Law Publisher, 1878.

It is a noteworthy fact that, although there have been published a number of excellent treatises on Medical Jurisprudence in general, and two, notably upon the Medical Jurisprudence of Insanity, no similar work to the above has yet appeared in the United States. It covers a ground so little explored by ordinary writers, and brings together in one body of systematic law, so many isolated decisions bearing upon every possible legal relation of lunacy, that it may be said to form a complete code of lunacy practice. While it embraces commentaries upon the lunacy statutes of New York, it also discusses the judicial aspects of Insanity at Common Law and in Equity, in such a way as to adapt it to the jurisprudence of all the States, whether in dealing with the principles or the practice of this branch of our municipal law. It will be found, therefore, equally serviceable to lawyers, committees of lunatics, superintendents of asylums, and to all occupying any official relations to the insane. It is a manual of the legal principles under which every question of insanity must ultimately be considered and adjudicated in a Court of Justice.

Prof. Ordronau begins his work with an introductory chapter upon the medico-legal reasons underlying the established traditions of the law upon the subject

of insanity. He then gives us a comprehensive digest of the adjudicated principles therein, as settled in England and the United States. His first chapter is devoted to a sketch of Lunacy Legislation in England, including present methods of commitment and official supervision, followed by a full History of Lunacy Legislation in New York. In the next chapter on the Revised Lunacy Statutes of New York, he begins his labors as a commentator. All questions relating to commitment, confinement, certificates, domicile, furloughs, superintendents of asylums, &c., are here discussed. He then passes on, in his next chapter, to the consideration of Habitual Drunkards, to whom he devotes the entire chapter. This is followed by another on the Special Acts relating to Counties.

At this point he begins the consideration of the judicial aspects of insanity by a chapter on Procedure, containing eight distinct titles, viz: Jurisdiction of Courts; Commissions of Lunacy; Inquests of Office and their Effects; Traverse; Supersedeas; Committees; Suits for, and against Lunatics; and Costs. The sixth chapter discusses the Civil Disabilities of the Insane, as affecting contracts of every kind; Conveyances, Agency, Partnership, Torts and Divorce. The seventh chapter deals with the question of Testamentary Capacity in all its Bearings, and we need not say how wide these are where such questions as delusions, undue influence, habitual drunkenness and disease are introduced into the problem. This is followed by an inquiry into the testimonial capacity of the insane. Chapter eighth takes up the subject of the Criminal Responsibility of the Insane, followed by a discussion on Epilepsy in its relations to Crime. Chapter ninth is dedicated to Forms in Lunacy Proceedings.

From a review of the foregoing synopsis it will be seen how large is the field covered by this work. Many of the subjects treated in it, can not be found in any works on Medical Jurisprudence, or even works on Insanity. They are living subjects to those who have any official relations to the insane, and sometimes give rise to perplexities which medical skill alone can not solve. As the author himself says in his preface:

These commentaries are largely compiled from cases that have been submitted to me for official determination. For although the Commissioner in Lunacy exercises no judicial functions outside of his visitatorial powers over asylums, yet it has devolved upon him to impart legal advice, both to professional practitioners and to public officers, in matters affecting either private rights or conflicts of jurisdiction, where, from the nature of the personal interests at stake, or the character of the jurisdiction involved, it was undesirable to bring them into the forum of remedial justice. These interpretations, therefore, are based upon living statutes, and rest in analogies drawn from judicial decisions both in law and in equity. They are simply opinions upon the practical applications of our Municipal Law to the subjects under consideration.

Insanity in Ancient and Modern Life, with Chapters on its Prevention. By DANIEL HACK TUKE, M. D., Fellow of the Royal College of Physicians, London. London: Macmillan & Co., 1878.

This work is an octavo of 220 pages, written in a style as pleasing and lucid as its subject would warrant.

Part First, which comprises nearly half the volume, is devoted to the Prevalence of the Causes of Insanity among the Nations of Antiquity: Although there are many interesting facts in these chapters, the general impression left upon one's mind after perusing them, is that it is all too supposititious—the existence of the causes not infrequently being only implied—and, still more frequently, their operation being but inferential. Although certain conditions were known to exist among

the ancients, which conditions do now sometimes produce insanity, it is hardly safe to imply that they then produced it to the same extent as now, or even at all. We have very little definite information as to the prevalence of insanity among the ancients, and this knowledge is not likely to be added to by any amount of theorizing.

Part Second, upon Insanity in Relation to Modern Life, is tangible and satisfactory; and part Third, upon Auto-prophylaxis, is well adapted for perusal by those who have not had much experience with the insane; in other words this, as indeed the entire book, is written in a popular style, and evidently not intended as a scientific or professional treatise. In good part it is an amplification of some of the chapters of the author's first edition of *Psychological Medicine*.

The Source of Muscular Power. Arguments and conclusions drawn from Observations upon the Human Subject under Conditions of Rest and Muscular Exercise. By AUSTIN FLINT, JR., M. D., Prof. of Physiology and Physiological Anatomy in the Bellevue Hospital Medical College. New York: D. Appleton & Company, 1878.

For several years the idea has been entertained by many physiologists, that the muscular system is a sort of machine through which the force inherent in food is manifested, like as in the steam engine the force inherent in fuel and water is demonstrated. In this little work the author gives his own observations and what seem to him to be the logical conclusions to be drawn from them, and from experiments made by others upon the human subject under conditions of rest and of muscular exercise. From these he arrives at the conclusion that no satisfactory determination may be made as to the amount of force to be derived in the body from a

certain amount of food, on the basis of force produced by chemical action outside the body.

The development of muscles in size, hardness, power and endurance by systematic exercise, with proper intervals of repose for repair and growth is due to increased activity of the circulation in the muscles and of the nutritive processes which not only renews the used up material, but adds still more.

"The direct source of muscular power is to be looked for in the muscular system itself. The exercise of muscular power immediately involves the destruction of a certain amount of muscular substance of which nitrogen excreted is a measure. Indirectly nitrogenized food is a source of power, as, by its assimilation by muscular tissue, it repairs the waste and develops the capacity for work; but food is not directly converted into force in the living body, nor is it a source of muscular power, except that it maintains the muscular system in a proper condition for work."

Physics of the Infectious Diseases. C. A. LOGAN, A. M., M. D.,
Chicago: Jansen, McClurg & Company, 1878.

This little work—a duodecimo of 212 pages—is the outgrowth, more especially, of the author's life in South America, during which he carefully observed the connection between the physical condition of the country and the diseases which prevailed. The book opens with some general observations upon the atmosphere as a medium for transmitting disease and the geography of disease. Then follow several chapters on the physical aspects of the Pacific coast of the South—then four chapters upon the medical aspects of the same coast. Part fourth is upon the physics of specific causation, which is very largely theoretical. Part fifth is devoted to the therapeutics of the infectious diseases;

and the last division of the work discusses the question of energy as related to general disorders. Although there is much in the book that is purely speculative, there are also many interesting facts, and the tendency of the book will be to incite its readers to a more careful consideration of the relation between disease and climatic conditions.

Tenth Annual Report of the Inspector of Asylums, Prisons and Public Charities for the Province of Ontario: Toronto, 1877.

This report is an octavo of nearly four hundred pages, well arranged and thoroughly prepared. Part first is devoted to Asylums for the Insane—comprising those at Toronto, London, Kingston and Hamilton, and the Asylum for Idiots, at Orillia. Elsewhere we notice the reports of the Toronto and London Institutions. In the Asylum at Kingston there were 380 patients at the close of the fiscal year, and in that at Hamilton, 199; making a total in the four Provincial Asylums of 1,859. The Asylum for Idiots contained 140.

The asylum accommodation of the Province increased during the year from 2,009 to 2,091, and the additions to be made at London and Hamilton are to increase it to 2,651 by the first of November next.

The total number of insane and idiotic publicly accommodated at the close of the fiscal year, including those in Kingston Penitentiary and County Gaols was 2,052.

Mr. Langmuir remarks that "it is most difficult to ascertain the number of persons of unsound mind who are at large, or even to make an approximation of it. It is, however, satisfactory and encouraging to know that the increased accommodation lately provided, has very appreciably reduced the number of unawarded applications for asylum accommodation."

During the year, 544 patients were admitted to the various asylums of the Province. There were discharged—recovered, 152; improved, 37; and 22 unimproved. The total deaths were 137.

The percentage of recoveries upon admissions was about 28.

In the accounts of the Inspector's visits to the various institutions, there is much of interest, and altogether the report is a valuable one. An appendix contains the reports of the superintendents of the several asylums.

Ninth Annual Report of the State Board of Health of Massachusetts: January, 1878.

The general report of the Board discusses various subjects that have been brought to their attention and investigated and acted upon by them, such as abattoirs, fat-vending establishments, fertilizing companies, &c.; recommends a bill to provide for the more accurate registration of vital statistics; calls attention to drainage, sewerage and pollution of streams; refers to the investigation by Dr. Jay Jeffries, into color blindness; recommends that attention be given to this subject, particularly with reference to employees upon railroads, steamboats, &c., where colored signals are used; recommends attention to Dr. Nichol's paper on the Filtration of Potable Water, and to Dr. Lincoln's paper on Sanitation of Public Schools in Massachusetts, as well as to Dr. Johnson's able and extensive discussion of Scarlet-fever; Hydrophobia, Diphtheria and prevalent diseases are also discussed, and altogether the report is a very worthy and readable volume. With this general report are given the various papers referred to, all of which are both full and able.

Report of the State Commissioner in Lunacy to the Legislature on the Relations of the State to the Society of the New York Hospital: Roslyn, N. Y., 1878.

This document is the outgrowth of a letter addressed by the President of the Board of Commissioners of Public Charities and Correction, of the City of New York, to the Governors of the Society of the New York Hospital, asking if they could not aid in furnishing provision for the pauper lunatics of the city and county of New York, its own asylums being so overcrowded. The reply intimated no desire or intention on the part of the Governors of the Hospital to afford any relief to the commissioners. Mr. Brennan accordingly called the attention of Dr. Ordonaux to the matter, and the latter made a thorough investigation into the relations of the Society to the State. He discovered that the State has, since 1797, given to the Society \$1,279,729.17, and that between 1816 and 1866 over \$440,000 of that sum was given specifically for the construction of the Bloomingdale Asylum. Also, that since 1822, by a statute then passed, the Society has been exempt from taxation on all real and personal property—an immunity to the Bloomingdale property alone which “a reasonable conjecture will not place at less than \$500,000;” and this “without any return made by them (the Asylum Managers) through that Institution to the insane poor of the county of New York.” He shows, moreover, that the original charter implied that the Institution should be a *charitable* one.

The Doctor makes a long and exhaustive argument, replete with legal references and decisions, and concludes “that the State may direct the use to which its funds, invested in the Bloomingdale Asylum, shall in future be put, and, as its founder, it may also appoint its own visitors to that Institution, because the power

of appointing visitors to any corporation is always a prerogative right in its founder."

The Commissioner closes his report by recommending "that it be referred to the Attorney General to determine—

First, what duty the Corporation of the New York Hospital owe to the State in respect to making provision for the pauper insane of the county of New York;

Second, what legislation is necessary to enforce such duty; and,

Third, whether the State has power to appoint, as founder of the Bloomingdale Asylum, a board of governors for its management."

This subject is now in the hands of the Attorney General.

Fifth Annual Report of the State Commissioner in Lunacy for New York: Roslyn, 1877. JOHN ORDRONAUX, M. D., LL. D.

In beginning his report, the Commissioner defines his duties as "those of supervision of the personal security, comfort and medical treatment of the insane," having the authority "of inquiry into, and remedying personal wrongs to the insane, while actually in the custody of asylums."

In his preceding report to the Legislature, he asked to be empowered to employ a stenographer, and also to have it made incumbent on the district attorney, in any county, where an investigation was to be made by the Commissioner, to attend and represent the people, since it was very unsatisfactory for the Commissioner to act both as prosecuting attorney and judge. Such a bill was favorably reported upon, but failed to become a law, and these requests are repeated in the present report. The subject of public visitation of asylums is discussed, and statistics given.

The Commissioner not only approves of County Asylums for the pauper chronic insane, but deems them a necessity, though he does not approve of their being managed as appendages to a poor-house, nor that their governing boards should have a political character.

If it were possible to create non-political boards of managers for such institutions, giving them at the same time a sufficiently long term of office to secure the benefits of their experience when acquired, instead of changing the whole board at one time, or even a majority of the old members, a great improvement could be made in the administration of these institutions. Let these boards be appointed by the highest authorities of the county, such as the county judge, the surrogate, and president of the board of supervisors. Let them consist of unsalaried freeholders of both sexes. Give them the power of appointing and removing the superintendent of the institution, and of determining the scale of its expenditures and the appropriations needed, and we should then secure the least objectionable form of government for all charitable institutions that can be devised.

The Commissioner also recommends a State Asylum for Epileptics, which we think a very wise suggestion, for there are many reasons why they should not be associated with ordinary cases of insanity in asylums. He urges the removal of the Asylum for Insane Criminals to some locality free from the objectionable features surrounding the present institution—a densely populated portion of the city—the proximity of a prison, and of manufacturing establishments—all disturbing to the class of cases that would be benefitted by treatment in a quiet region. "If the State really means to cure such patients, it should, above all things, secure them a quiet retreat. If it merely intends to secure their custody apart from the labors of a prison, then the place may answer. * * The institution should be placed in the midst of a farm, with space enough for secure seclusion on the one hand, and occupation on the other, to the inmates." He recommends the Legislature

to appoint a commission to consider and report upon the expediency of the removal of this Asylum, and of placing it upon the same basis of management as the other State Asylums.

The succeeding section of the report details the repairs and improvements that have been made in the County Asylums, especially noticeable in Broome, Chautauqua, Columbia, Erie, Oneida and Rockland counties.

Dr. Ordronaux makes some suggestions upon insanity and crime—describing particularly, and with rare force of rhetorical figure, a class of criminals who occupy the border-land of insanity, and so are almost without the bounds of responsibility—"unfortunate human beings, born misshapen and lop-sided in mental constitution, social Ishmaelites from birth, and pirates in every community where they dwell. *Hostis humani generis*, they are, indeed, sad victims to inherited degenerations, traveling fast through highways of scrofula, syphilis and glandular disorders, down into the regions of insanity and consumption." The State, he thinks, should "separate the mentally undeveloped criminal from his more perfected fellow-sinner, and thus endeavor to create in him a conscience toward the State, at least, as the parent of laws, which all must obey." He believes that it would further the successful administration of prison reform to weed out, periodically, from the ranks of their inmates, all criminals of doubtful mental capacity; "weak minded youths, adult imbeciles, demented men, or those in the incipient stages of insanity, should be transferred to the State Asylum for Insane Criminals, there to serve out their sentences;" and he recommends that the Superintendent of that Asylum visit, quarterly, each of the State prisons, to ascertain, by personal examination, what convicts should be transferred to the Asylum.

The report closes with some remarks upon the State Inebriate Asylum, regarding which he deems additional legislation necessary to give that disciplinary and restrictive character to the treatment of its inmates, which the reformation of inebriates demands. In addition to what we have already noticed, the report contains a section upon Statistics of Criminal Lunacy in England, and there are several pages devoted to statistical tables regarding the various asylums of the State, both public and private.

Report of the Visiting Committee to visit the Hospitals for the Insane: Des Moines, Iowa, 1877.

This committee, which consists of two gentlemen and a lady, appears to have a general supervision of the patients in asylums; to see that they are well-cared for and treated, and that they are not improperly detained in the custody of the Asylum. The report is very favorable to the institutions in Iowa. After complimenting the diet, beds, cleanliness, etc., the committee remarks that "nine-tenths of the inmates of these hospitals are better lodged and fed, and better cared for, personally, than they ever were in their lives before," which is saying more for the institutions than for the people of the State.

Two charges were brought against the Hospital at Mount Pleasant. One was that a patient had been cut and bruised by an attendant kicking him. Investigation showed satisfactorily that the injuries were due to falls in epileptic fits, to which the patient was subject. The other was a case of a woman, who had been in the Asylum a year and a half, and who, when she escaped and returned to her friends, had gained so much in flesh as to give credence in their minds to her statement that she was pregnant. A Dr. Cook saw her upon the

street, and upon this very superficial examination testified under oath to the opinion that she was in that condition, and with justice the committee censures him severely. After a month the woman was returned to the Asylum, where she now is. A thorough and satisfactory investigation was made, which convinced the committee that the charge was not true. The committee deprecates the practice of sending criminals convicted of capital crimes to the hospitals for the insane; and recommends that a suitable ward be provided in the penitentiary for the care and treatment of such cases.

SUMMARY.

—Eight or ten years ago Jonathan Burr, a wealthy resident of Chicago, died, having bequeathed a certain property to the benefit of any State asylum that might be established in Northern Illinois. The commissioners of Cook county built an addition to their alms-house for the use of the insane, thinking thereby to secure the generous gift. The institution was not, however, a State Asylum, and when the Asylum at Elgin was erected, action was taken by the Board of Managers, through their attorney, Mr. Holden, to secure possession of the property. The case was tried in the Circuit Court of the county, resulting after a year and a half in a decision in favor of the County Institution. Appeal to the Supreme Court, however, reversed this decision, and the deed is now in the hands of the Elgin Asylum managers. The property is worth about \$35,000. Only the interest can be used, and that "for the comfort and benefit of the insane, by furnishing them more ways of diversion and amusement."

—Dr. Wm. M. Compton, who recently resigned the Superintendency of the State Lunatic Asylum at Jacksonville, Miss., will open a Private Asylum at Holly Springs, Miss., about the first of December next. The Institution will accommodate about thirty patients. We wish the Doctor abundant success in his new enterprise.

—Dr. Wm. A. Gorton, of Cooperstown, N. Y., has been appointed Assistant Physician to the Asylum for Insane Criminals at Auburn, N. Y., in place of Dr. Gerin, who has gone into private practice in Auburn.

—Dr. Horace Wardner, of Cairo, Ill., has been appointed Superintendent of the Southern Illinois Insane Asylum at Anna, as successor to Dr. Barnes, resigned.

—Dr. T. J. Mitchell, has been appointed Superintendent of the State Lunatic Asylum at Jacksonville, in place of Dr. Compton.

—Dr. George C. Catlett has been re-elected Superintendent of the State Insane Asylum, near St. Joseph, Mo., to serve for the ensuing four years.

ERRATA.—In article on "Insane Patients and their Legal Relations," July number, page 182, sixth line from bottom, read *uses* for *cases*; and on page 185, fourth line from top, read *natural* for *national*.

AMERICAN
JOURNAL OF INSANITY,
FOR JANUARY, 1879.

AN ABSTRACT OF THE LAWS OF THE
STATE OF NEW YORK,

IN REGARD TO THE COMMITMENT OF INSANE TO ASYLUMS, THEIR
DETENTION AND DISCHARGE, AND COMPARISON OF THE SAME,
WITH THE STATUTORY PROVISIONS OF ENGLAND.*

BY JOHN P. GRAY, M. D., LL. D.

Two broad considerations underlie this subject,—the welfare of the individual, and the safety of the public. The question of unnecessary interference with personal liberty, and the possibility of confounding sane and insane in the application of laws made to protect the latter, as well as society, are vital considerations. It is a fact and practically an axiom, that insanity implies or includes the necessity of special laws to meet the conditions which grow out of it, or in other words, to meet the symptoms and results of the disease itself. The laws upon the subject differ in various countries, as well as in the various States of our country. The objects everywhere are to determine what constitutes insanity, what degree or character of insanity produces loss of accountability for acts, or necessitates provision for the government of the person or property, and finally, confinement in hospitals, asylums, retreats, etc., for treatment and safety.

*Address as President of the Association of American Medical Editors, delivered at Buffalo, N. Y., June 3, 1878.

I do not propose here to enter into the subject generally, but only in relation to the methods of determining the question of lunacy, in any given case, for the commitment to, detention in, and discharge from institutions, authorized under legal statutes, for the treatment and care of the insane. This subject has received great attention by men eminent both in the medical and legal professions, and the fact that the laws so widely differ both in their construction, established methods of procedure, and the officers authorized to administer in their execution, tend to show the inherent difficulties that underlie it, both as a matter of law and social polity. Such laws necessarily call into requisition, in their provisions and execution, both medical and legal science; to determine the existence of disease, its degree, and the propriety of restraint by commitments, the detention and the restoration to liberty. The determination of these questions must rest largely upon the individual judgment of medical men. Cases of insanity differ largely in the mental manifestations, social and general surroundings and conditions, and the natural character of the individual, hence the difficulty of any general rule applicable to all cases.

In looking over the statutes of the several States, those of New York coincide more nearly with those of England than do those of any other State. The initial question is:—How is insanity to be determined? This issue was raised under the common law writ, *de lunatico inquirendo*, in any individual case suspected, and this went directly to the question of personal liberty. The laws of England require that any person brought within their provisions must be certified on medical authority to be "either a lunatic, or an insane person, or an idiot, or a person of unsound mind." The statutes of New York, now in force, [Chap. 446 Laws of 1874. "An Act to revise the

Laws of the State, relating to the care and custody of the insane; the management of the asylums for their treatment and safe keeping; and the duties of the State Commissioner in Lunacy." provide that "the terms lunacy, lunatic, and insane, as used in this act, shall include every species of insanity, and extend to every deranged person, and to all (cases of) unsound mind other than idiots." For idiots, the law has made certain special provisions. While it is difficult in a statute to enter into a scientific definition of insanity or do more than use a succession of terms which are rather synonymous than definitions of each other, it is found practicable to lay down some rule by which the insanity may be established, justifying and requiring confinement. What in law constitutes an insanity sufficient to confine, is involved in the provisions authorizing the medical certificates, as an initiatory proceeding, necessary in all cases. The certificates declare in terms that the person "is insane, and a proper person for care and treatment under the provisions of Chapter 446, Laws of 1874," and recites the reasons therefor. This establishes the lunacy and the necessity of confinement. The commitment becomes legal by the approval of the certificates by a judge, and thus the commitment and detention are made legal.

CERTIFICATES OF INSANITY.

ENGLAND.

Medical Certificates—Number and Time for Making.—Two medical certificates must be made out, in the case of private patients, within seven clear days from the date of the examination by the physicians; in the case of pauper insane only one is demanded, and the patient must be admitted within seven days of the examination. No medical certificates are required for chancery patients.

NEW YORK.

Medical Certificates—Number and Time for Making.—The certificates of two physicians are required in all cases, and must be made out within ten days of the examination by the physicians, and the patient must be admitted within ten days of such examination, or a new certificate is required.

ENGLAND.

Qualifications.—Physicians making certificates must be in actual practice and duly registered. No medical attendant in an asylum can make a certificate, and no physicians having proprietary interest in, or who receive any percentage of profits from an asylum. The medical certifiers must not be in partnership professionally, nor can the certificates be signed by the father, brother, son, partner or assistant of the person having charge of the patient, and no physician who signs the order or request for admission to an asylum can sign the medical certificate.

Exceptions.—When there is but one medical man in a village, and the case is urgent, the patient may be admitted on this certificate, but must be examined after admission, and within three days, by two other physicians.

Character of Certificate.—The facts upon which the opinion of a medical man is based must be stated in the certificate, and as observed upon the day of examination; and every statement designated as a delusion, verified; and hear-say statements must be designated as such and the names of the persons giving them, must be mentioned.

Approval of Certificates.—Exact copies of all medical certificates (with any interlineations and erasures) must be sent to the Commissioners in Lunacy within twenty-four hours after the admission of the patient, for approval, and if imperfect, they must be returned for correction, and if not corrected within fourteen days, the patient must be discharged.

NEW YORK.

Qualifications.—Physicians making certificates must have been in actual practice at least three years, of reputable character, graduates of some incorporated medical college, a permanent resident of the State, and all such qualifications must be certified to by a judge of a court of record. No physician can make a certificate committing a patient to an institution of which he is either the superintendent, proprietor, officer, or regular professional attendant.

Exceptions.—None.

Character of Certificates.—They can only be made after a personal examination of the party alleged to be insane, and must be according to forms prescribed by the State Commissioners in Lunacy. The facts upon which the opinion of the medical man is based must be stated in the certificate and all duly certified under oath.

Approval of Certificates.—All certificates must be approved by a judge or a justice of a court of record of the county or district in which the alleged lunatic resides, and no person can be held in confinement for more than five days without such approval.

Proofs.—Before approving or disapproving of certificates of lunacy, the judge or justice may institute inquiry, take testimony as to any alleged lunacy, and in his discretion call a jury in each case to determine the question of lunacy.

COMMENTS.—It will be observed that upon the matter of certificates the British and New York statutes agree in main essential points. In New York, the law gives three days more for making out certificates and getting a patient to the asylum; makes three years practice essential in an examiner in lunacy; while the English law specifies no time. The English law extends the list of those who are excluded by interest or relationship from making out certificates. The English law prescribes more specifically how the facts observed and acquired from others, and upon which opinion is based, shall be set forth in the certificate. The English law simply requires the approval of the certificate by a Commissioner in Lunacy, and fourteen days are allowed for correcting defects, while in New York, the Commissioner in Lunacy only prescribes the form of certificate, while its approval must be by a judge or justice of a court of record in the judicial district where the alleged lunatic resided, and must be done within five days: furthermore, New York provides the still greater safeguard that before approving the certificate, a jury may be impaneled on the option of the court.

There is this further guarantee in the New York statute:—If any insane person, or any friend in his behalf, is dissatisfied with any decision or order of any county or special county judge, surrogate, judge of Superior Court, or Court of Common Pleas, or police magistrate, he may take an appeal, within three days, to the Supreme Court, who shall stay proceeding and forthwith call a jury to decide upon the facts of lunacy. The court shall, in making investigation, call at least two respectable physicians, and if the jury find the person sane, the justice shall discharge him or otherwise confirm the order sending to the asylum.

Thus it will be observed that while the legal processes are simple and unobstructive, they nevertheless amply

guard the rights of the individual, and in New York more especially place the whole, at every step, under judicial protection, though the intent of the law is evidently to rest the determination of the actual question of insanity upon medical authority.

Since the law of 1874 went into operation, over sixteen hundred patients have been admitted into the Asylum at Utica, and I have reason to know that the approval of judges is not a mere ministerial act. The defects in certificates have been mainly failures by the medical examiners to give sufficient detail of the facts upon which they have based their opinions.* During the four years of the operation of the law, about two and one-half per cent of the certificates have included as insane, cases of intemperance with violence and peculiarities, of hysteria, and of meningitis. During the four years previous, about three per cent of the admissions were of this same class.

As evidence of the good faith of medical men, and the integrity of public officers, and friends seeking admission for patients at private charge, I can state that in an experience of twenty-eight years and the reception of ten thousand patients, there have been but three attempts to get persons into the asylum under improper motives, two public and one private. The other cases, admitted and discharged not insane, were of the classes already mentioned and criminals who had either successfully feigned insanity, or been acquitted by juries on the ground of insanity.

* As this paper goes to press, a certificate is received at the Utica Asylum, with the following endorsement:—"Not Approved. This certificate is entirely insufficient in form. The facts indicating the insanity, must be stated and should (in the true spirit of the law) be stated in such detail as to show upon the face and mere statement, that the patient is insane. A perusal of the certificate will show that the examining physician has already stated his opinion,—he should also state his reasons for such opinion. They should be so particularly stated as to convince another reading them, that his opinion is well founded and correct."

Why should the law authorize the courts to approve practitioners generally as medical examiners, instead of constituting a small board of expert examiners?

First,—The qualifications are expressly set forth in the law, and all medical men who possess them should be equally entitled to be made medical examiners.

Second,—This permits the family physician, who is necessarily conversant with the facts of the case, to act as an examiner and to name to the family a second examiner. It thus preserves the rule in regard to consultants, and gives the liberty to any family to say what physicians shall be brought within its confidence.

Third,—If the public officer, or court designated only a few examiners, those might be appointed in whom neither the family, nor the family physician, had confidence, and a speculative class would be likely to seek and secure the appointments, and the office of examiner might soon become one of mere political reward, which the best men in the profession would avoid.

Fourth,—In the sparsely settled districts, unless general practitioners were selected, great expense would ensue from the examiners having to go long distances, or the alleged lunatic being transported to their offices.

Fifth,—An alleged insane person should always be examined at home under ordinary surroundings, with as little unnecessary official show, excitement, parade or exposure as possible, and the privacy of families and family affairs should be as carefully kept as in any other disease. All this will be better secured where the family physician and *confrere* are employed.

COMMITMENT OF THE INSANE.

ENGLAND.

Commitment.—An order, a statement and the medical certificate already mentioned are required. *

NEW YORK.

Commitment.—An order, a statement recorded in the case-books of the institution, and two medical cer-

ENGLAND.

Pauper lunatics are sent to asylums upon the order of the parish relieving-officer, acting with a clergyman or justice, accompanied by the certificate of a physician, surgeon or apothecary, and a statement which is to be filled out with exactness in the form of answers to questions, embracing the history of the patient.

Private patients are admitted on an order signed by a relative, friend or some person authorizing them to be placed under restraint, and the person signing the order must have seen the patient within one month of its date, and this person becomes responsible for the payment of the expenses of the patient while in the asylum. This order is in the form of a written request, and must be accompanied by a statement similar to that required in the case of paupers, and two medical certificates.

Chancery patients are committed on "an order signed by the committee appointed by the Lord Chancellor, and having an office copy of such appointment annexed."

Criminal lunatics are committed under order of the courts.

NEW YORK.

certificates are required for public patients, and a bond in place of the order for private patients.

Pauper patients are admitted on an order of the Superintendent of the Poor, of the County in which the patient resides, accompanied by the two medical certificates already mentioned. State paupers are committed with certificates on an order of the Secretary of the Board of State Charities.

Indigent persons, who are in such limited circumstances that they can not "support themselves and their families under the visitation of insanity," are committed under the order of the County Judge after proof of indigence, and that the insanity is not over a year's duration, accompanied by two medical certificates.

Violent and dangerous insane, whom their friends neglect to confine, are also sent by the county judges, with two certificates. Criminal insane are committed by order of the courts.

Private patients are admitted on a bond, executed by responsible parties, for their maintenance, and accompanied by two medical certificates.

A statement and history of all public and private patients, in all institutions, must be recorded in the case-books within three days after admission.

In county and municipal institutions for pauper insane, the commitments are under special Acts, which include commitment by local commissioners of charities and corrections, police justices, and other municipal authorities, but in all cases the two medical certificates, judicially approved, are required.

COMMENTS.—It will be observed that in England, judicial authority is not invoked in commitment of any of the insane, and that private patients may be confined on an order, signed by any one, whether that person be a friend, relative, or even an entire stranger, and that a month may elapse between the time of this person seeing the alleged insane person, and granting the order for his admission, and that for pauper insane but one certificate is required. It is evident, that the guarantees, both for private and pauper patients, are greater under the New York statutes, than under the English.

SUPERVISION AND VISITATION.

ENGLAND.

Supervision.—The officers charged with this duty are Masters in Lunacy, Commissioners in Lunacy, Visitors and Borough officers. There are two Masters (with salary) in lunacy who act as judges in all proceedings under the writ *de lunatico inquirendo*, who are barristers of ten years, or sergeants-at-arms, and are appointed by the Lord Chancellor.

There are six Commissioners in Lunacy, (with salary); three medical men and three barristers, who act as visiting commissioners; there are also six commissioners, non-visiting, and these latter are unpaid. Commissioners must have been in medical or legal practice five years. The board grant licenses to corporations, or private individuals to open asylums, visit and regulate asylums, report to the Lord Chancellor their condition, conduct and management, and all matters connected with the certified lunatics in England and Wales. They visit all licensed houses within the limits of certain territory, (four of these visits are made conjointly by a medical and legal

NEW YORK.

Supervision.—The officers charged with this duty in New York, are the State Commissioner in Lunacy, the State Board of Charities, Boards of Managers, Municipal Boards, and Commissioners appointed from time to time in special cases under courts.

Special commissioners are appointed by the Supreme Court, as the exigency arises in cases of writ *de lunatico inquirendo*.

The Governor of the State has the power also to appoint at any time a special committee of visitation and examination.

The State Commissioner in Lunacy (with salary), is appointed by the Senate, on nomination by the Governor, and is charged with the visitation of all asylums, public and private, and is authorized to inquire into their management and conduct, and report annually to the Legislature, and to make investigations into any alleged negligence or improper treatment of the insane, and in the name of the people of the State to issue an order for the remedy of any negligence, improper treatment or provision, and to report

ENGLAND.

commissioner, and two by a legal commissioner,) and see all the inmates and examine as to the number admitted, discharged, died, etc. Their jurisdiction is London and Westminster, and county of Middlesex, and borough of Southwark and certain places of counties Surrey, Kent, Essex and "every other place within the distance of seven miles from any other part of London, Westminster or Southwark."

All other houses or asylums are visited by Commissioners nominated annually in each borough, consisting of three or more justices, who act gratuitously, and one or more medical men who receive remuneration. Three, one a medical man, visit four times a year, and two other visits must be made by one or more of these commissioners, with two visits of supervision by a barrister and medical man.

Two or more of the commissioners are empowered to visit all work-houses and jails where lunatics are confined.

Lord Chancellor's Visitors.—These are three, consisting of one legal and two medical visitors; they are required to visit all chancery patients in asylums as well as those in private dwellings, all being under their jurisdiction.

In the Parliamentary report of the select committee, Dr. C. Lockhart Robertson presents the following tabulation, showing amount of visitations of private lunatics (not paupers) by chancery visitors and commissioners:

The Statement.

I. Chancery Visitors: Patients in asylums, one visit yearly; patients in private dwellings, four visits yearly.

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to the Supreme Court for relief if the order is disobeyed or negligently executed.

He also visits all chronic lunatics in the custody of the county asylums organized under a license from the Board of State Charities, and those confined in municipal and city asylums, on all of which he reports annually to the Legislature.

The State Board of Charities consists of eight members, one from each judicial district, appointed by the Senate upon nomination of the Governor, and, excepting the Secretary, serve without pay. They are empowered to visit and examine into the condition of all charities of the State and all institutions, public or private, where insane are under treatment or in custody, to inquire into their government and management in all respects and the condition and treatment of patients.

Boards of Managers are appointed by the Senate, on nomination of the Governor, and have entire control and direction of State asylums and appoint the chief officers, establish by-laws, rules and regulations. A Board is appointed for each institution, the members of which act without pay. A majority is required to visit the asylums once a quarter, and the whole Board once a year. They have the power to regulate the admission and discharge of patients, and control and direct the entire financial affairs, and are required to report annually to the Legislature, within fifteen days after the opening of the session. These boards consist of eight or more members in each.

The municipal boards are local boards created under laws authorizing the organization of municipal and county asylums, over which they have full power of visitation and control.

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II. English Commissioners in Lunacy: Metropolitan licensed houses, six visits yearly; provincial licensed houses, two visits yearly; lunatic hospitals, one visit yearly; patients in private dwellings, one visit yearly; (not chancery lunatics.)

III. Scotch Commissioners in Lunacy: Patients in asylums, two visits yearly; patients in private dwellings, one visit yearly.

Licenses.—Persons or corporations desiring to take out licenses to open and carry on asylums, large or small, must make applications to the board at least fourteen days before a stated meeting of the Commissioners. This must state the number of patients, the sex and the arrangements for separation, must give the place of the house, number and size of rooms, and quantity of land attached, and whether for public or private patients.

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Licenses.—The State Commissioner is authorized to license private asylums, and every application must be accompanied by plans of the premises, a description of the buildings, the extent and location of the grounds, the number of patients of each sex proposed to be accommodated, and after a personal examination of the premises, if he finds them suitable, he may grant the license.

The State Board of Charities have power to grant licenses to counties to erect and organize asylums for the chronic insane, and to fix the rules and regulations for their government, and to withdraw the licenses if they are not properly conducted.

COMMENTS.—It will be observed that under the English and New York statutes, there are visiting, controlling and local boards, with varied functions and duties similar in character, and so constituted as to embrace all the interests, requirements and rights of the public and individual, growing out of the establishment of institutions for the insane of every grade and character, and securing the personal liberty of those committed to them as far as the conditions arising in the disease will justify.

In a recent report of a special Parliamentary committee on lunacy laws, a printed quarto of six hundred pages, a large number of prominent men were examined; at the conclusion Rt. Hon., The Earl of Shaftesbury, who has been on the English Lunacy Commission nearly fifty years, and permanent chairman since 1845,

who was also member of the first committee of inquiry in 1828, and who had, by permission of the House of Lords, been attending this investigation, gave his views at great length. He stated: "I cannot recollect a single instance in which a patient has been brought into an asylum in whose case there was not sufficient grounds for saying that he was the proper subject for care and treatment. I can hardly recollect a single instance. I see by referring to the evidence which has been given before your honorable committee that such is the testimony of every man of experience who has been consulted on the matter." To the question, "At the same time there is a feeling which has been expressed not only generally but by witnesses before the committee, that a large number of persons are admitted into asylums in a state of sanity and kept there?" he replied, "I have no doubt those statements would be made, because I never knew the case of a patient, either under confinement or after confinement, who did not say that he had been most unjustly confined. I hardly know an instance." Question: "At any rate it is your lordship's opinion that the admission into an asylum is now sufficiently guarded?" Ans. "I think so." Ques. "Would you say the same with regard to their detention there; is it not the case that they are sometimes kept there longer than is necessary?" "I don't think they are so now." And he adds; "It is a very great responsibility, to send out a patient upon the world both with respect to the patient himself, and in respect of society, before you are satisfied that he is cured, or, at any rate, in such a state that he can be safely trusted."

When Governor Hoffman, of New York, in 1874, appointed General Francis C. Barlow, then Attorney General of the State, Dr. Thomas Hun, of Albany, and M. B.

Anderson, LL. D., President of Rochester University, a committee to examine into all institutions, public and private; they reported that no persons were improperly confined in the State, and no cases have since been reported either by the State Commissioner in Lunacy, or the State Board of Charities. Such facts go to show the efficiency of the law and the fidelity of the medical profession to the principles of science and humanity.

DISCHARGE OF THE INSANE.

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Discharge of Patients.—Private patients are discharged from any licensed house or hospital by the direction, in writing, of the person who signed the order of admission. If such person be dead, absent or insane, then the husband or the wife, the father, the mother, then the nearest of kin, or finally the person who made the last payment of account, may successively have power to give such order, and if there be no relative, friend or qualified person thus required to act to make the order, then the commissioners may direct the discharge as they see fit.

In the case of pauper patients the guardians of any parish or union, or an officiating clergyman of any parish not under guardians, with one overseer or any two justices of the county or borough may, in writing, direct the discharge or removal, provided they are not certified in writing as dangerous or unfit to be at large, by the medical officer in charge, of any pauper insane patient. Any two or more of the commissioners may discharge any pauper patient from houses licensed by themselves, after two visits, with seven days intervening, if such patient is detained without sufficient

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Private patients are discharged by the Managers of asylums, or may be removed by the persons executing the bond upon which they are received. Those who have been committed upon a warrant of a judge as dangerous to be at large, may be discharged upon the order of a justice of the Supreme Court, or if recovered may be discharged by the Board of Managers upon the Superintendent's certificate of recovery. Indigent patients are discharged by the managers upon recovery, and if not recovered in two years are liable to be removed after notification to the county judge, and they may also be discharged to the county authorities or friends by the board of managers. They may also be removed by their friends, though uncured, at any time before the expiration of two years, on presentation of a certified copy of a bond with sureties, approved by the County Judge of the county from which the patients were sent, the bond being filed in the county clerk's office. This bond must guarantee "the peaceable behavior, safe custody and comfortable maintenance without further public charge" of the lunatic so removed.

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cause; and for like reasons two commissioners, one a physician, may discharge any pauper patient from houses licensed by justices, but in all cases the medical attendant of the house or hospital shall be examined, if he desires to be, upon the subject before the discharge, and his statement shall be in writing and recorded.

No lunatic, certified to be dangerous, can be removed from any house or hospital, without first obtaining the consent of the Commissioners and Visitors.

Criminal insane are discharged by the courts, after due investigation.

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The managers, on the superintendent's certificate of complete recovery, may discharge the pauper patient, and whether admitted as dangerous or not, "upon the superintendent's certificate that he or she is harmless and will probably continue so, and is not likely to be improved by further treatment in the asylum." They may discharge any such patient to their friends upon the same guarantee as to safety, maintenance, &c., as mentioned in regard to indigent patients.

Criminal Insane.—A patient of the criminally insane class can only be discharged by an order of a justice of the Supreme Court, or a Circuit Judge, if upon due investigation it shall appear safe, legal and right to make such order.

Municipal and County Asylums.—In the counties of New York and Kings the County Commissioners of Charities having charge, discharge, but only on "the certificate in writing of the physician thereof, which certificate shall be filed and kept in said asylum, stating that such discharge is safe and proper."

No insane person can be discharged from any poor house or county asylum (excepting New York and Kings) except upon an order of a county judge or justice of the Supreme Court, "founded upon satisfactory evidence that it is safe, legal and right to make such discharge." Any other person or officer making such a discharge commits a misdemeanor and is punishable by a fine of not more than \$500 or less than \$100, in the discretion of the court.

COMMENTS.—In England and America, the provisions for the discharge of the insane are essentially the same. As in the initiatory proceedings for confinement, the

responsibility is mainly thrown upon the medical profession, so also is the responsibility of discharge. In the discharge of pauper patients there is no practical difference in the two countries. In respect to private patients, the statutes of New York are more simple and practically effective. In New York the managers of each asylum have the power to discharge without formality, and even without the assent of the relations or guardians, while in England the consent of the person who signed the request or order for admission must first be obtained, or his successor, which may cause delay, annoyance, or even work to the detriment of the patient. Indeed the parliamentary report spoken of, shows that the institutions have frequently to invoke the influence, and sometimes the official power of the commissioners to compel the removal of private patients. In New York the bond, or as termed by the English law, the order, on which private patients are admitted, provides for discharge "whenever he shall be required to be removed by the managers or superintendent," and in case of refusal, for the payment of "all expenses incurred by the managers or superintendents, in sending such patients to his friends." This compulsory provision has had to be enforced, at times, by the managers.

Of course, in both countries the writ of *habeas corpus* stands as an ever-present protection against any possible wrong. This, however, has not been appealed to but three times at the Utica Asylum since my connection with the institution, in 1850,* and in these three cases the patients were immediately remanded to the Asylum by the courts. The statute of New York provides against any probability of unnecessary or improper detention of private patients, under any circumstances, as it makes the delivery of the patient, by the officers, to the friends, a mere matter of request at any time, as the friends are

* Since that time there have been admitted 10,600 patients.

not even put to the slight inconvenience of making a formal order in writing, as in the English law, and the managers may discharge summarily.

Since writing the above, the State Commissioner in Lunacy, Dr. John Ordonaux, has brought out a very valuable work, entitled "Commentaries on the Lunacy Laws of New York, and on the Judicial aspects of Insanity at Common Law, and in Equity, including Procedure in England and the United States." He announces as the result of his observations and experience as a Lunacy Commissioner, of his studies in revision of the laws, and of his examination of institutions, that:—

"In the organization also, and management of our asylums, and the provisions made for the care of the pauper and indigent insane, this State has made great progress; and lastly, in establishing a system of supervision of its insane wards, it has completed its guardianship of all departments of its public charities.

"To unfold, therefore, the reason of the laws governing the civil and criminal status of the insane, has been the object to which I have addressed myself in these commentaries. They are designed to cover, not only the Revised Statutes of New York, but the whole field of those decisions in law and equity, which give rise to some of the most difficult questions in jurisprudence. And inasmuch as they would be incomplete as a manual, without some discussion of the practical methods of enforcing these laws, I have added a chapter on Procedure; prefacing the whole work with a digest of adjudicated principles in the Jurisprudence of insanity, together with a synoptical sketch of the development of our statute law, herein, in the form of a History of Lunacy Legislation in England and the United States."

MEDICAL EVIDENCE IN COURTS OF LAW.*

BY DANIEL CLARK, M. D.,

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Any one, who has paid even a superficial attention to medical evidence given in courts of law, must have noticed, from time to time, how easily medical witnesses can be procured to give evidence on both sides of a case. It matters not how clear may be the merits of the question, nor how little ground exists for difference of opinion, yet, medical men are found who will give positive testimony on either side, at the shortest notice, and on very flimsy premises. Lawyers take advantage of such conflict of opinion, and set up one medical man against another, until both judge and jury value the evidence by the reputed credibility and professional standing of each, and virtually neutralize the evidence of all by a system of offsets. This only refers to medical opinions, for in respect to facts, all witnesses—lay or professional—stand on common ground, and state what are matters of observation, "without note or comment." It is true, medical science gives room for great differences of opinion, seeing it has not the exactness of mathematics. Herein lies the error in dogmatizing on much which is so obscure. Many of these varieties of opinion arise from a vain endeavor to explain everything connected with causes of litigation. In the presence of a court and the assembled multitude it may not be pleasant to pronounce our ignorance; yet, in the endeavor to give answers hedged round with vain

* Read before the Canada Medical Association, at Hamilton, Ontario, September 12th, 1878.

hypotheses of all kinds, the medical witness is apt to have unpleasantly forced upon him a display of how little he knows under a cross-examination, and thus what would have been received as competent testimony, if it had been confined to sure opinion, is marred and rendered subject to doubt by the witness pretending to know too much. In the plethora of opinion lies one reason for so much contradictory evidence. It is well never to say more than the question covers, and to be guarded in even doing that, if the interrogation happens not to be relevant to the case at issue.

Another reason is in supposing ourselves as being witnesses for one side only, because we happen to be subpœnaed by one of the parties. The prosecutor or defendant, who calls a medical man, expects him to give *ex parte* evidence. He is paid a miserable pittance to cover railway and hotel expenses; is his testimony not bought and paid for, to be used on the disburser's behalf? This feeling, often involuntary, gets hold of the witness, and, immediately the examination begins, he is on the alert against the wiles of the opposite lawyer, and often unconsciously is put upon the defensive to the injury of the truth. We have all felt this tendency. This position is not intentional, but the badgering of an indiscreet lawyer, may drive a medical witness to defend opinions which may give a coloring to a case not intended at the outset. This bias has to be guarded against. The witness is in court to tell *all*, and *only* the truth, as far as in him lies. It is not for him to think of the result, consequent thereon, to any party. In giving evidence it is not safe to weigh what will be the consequences flowing from its acceptance. "Let justice be done though the heavens fall." Unfortunately medical witnesses, giving opinions based on experience, are looked upon with suspicion by the courts.

J. H. Balfour-Browne, in the last edition of "The Medical Jurisprudence of Insanity," says: "That medical testimony, when received, should be received as of very *inferior worth*." Medical witnesses are said to be "rash," and "to have expressed crude generalizations with an imperturbable effrontery," and that alienist physicians ask to be believed, "with an implicit faith, which is only compatible with the grossest ignorance; lawyers should assert the utter uselessness of the evidence of scientific witnesses in relation to questions of insanity." Lord Campbell says that "hardly any weight should be given to the evidence of skilled witnesses." Judge Davis declares in cases of insanity, "men of good common sense would give opinions worth more than that of all the experts in the country." A book might be filled with such choice quotations. If those who have made this branch of medical research a life long study, are such ignorant and unreliable witnesses, what shall be said of the intelligent thousands and tens of thousands in general practice?

It is also to be remembered, in cases of damage for malpractice, that each surgeon may have a mode of treatment distinct from any other, but sufficiently practical to be approved of in general practice, by any intelligent physician or surgeon. This treatment may be denounced by some one who is not able, from experience, to test its value, and an unlettered jury may decide the merits of the case in its professional aspects, by considering one method as only worthy of consideration, and give a verdict accordingly, to the astonishment of those best capable of judging. Next to the inscrutable ways of Providence stand the verdicts of juries, in their uncertainty and unforeseen results. This selection, by non-professional men, of one method of treatment, to the exclusion of all others, has been seen by me on several

occasions. At one time the prosecution was because of a shortened femur, and the merits of the double inclined plane or a straight splint, were decided by a jury selected from one of the back townships. Another was decided in favor of a flap operation as against a circular, the jury being composed mostly of farmers, fresh from the harvest field. Not long since I attended a trial in this city and the jury were treated to clinics on the *dura mater*, *arachnoid*, *pia mater* and their blood vessels. They understood the merits of the case, after several hours of medical dissertations, as much as if the Crown Council had given an address in Choctaw. I envied one jurymen who slept soundly through it all, except when elbowed by a neighbor.

Antagonisms unhappily existing among medical men lead to conflict of opinion. A case comes from a village, a town, or even a city. Observation teaches that the smaller the area from which such evidence is drawn, the stronger are the contentions in the locality, and the more likely does it become that sides are taken before the suit goes to court. It is a matter of every day experience that in a majority of cases, such a locality will furnish medical evidence for prosecutor and defendant. The reasons already given may have something to do with this diversity of conception. I fear unfriendly feelings, of a professional nature, must sometimes be taken into account. To the honor of our profession it is seldom that false testimony is given from motives of revenge. Animosity against a professional brother seldom reaches perjury, yet, a love of establishing proof on a different basis from that of a rival, often leads to false conclusions, not intended by the witness. If this itching for novelty leads to wrong impressions, they are still farther intensified by ambiguity, which may be caused by unnecessary economy of words, or

by the other extreme of profuseness of illustration, not conducive to perspicuity. Such being the case, a court refuses to reconcile contradictions among those who are supposed to know the merits of the case.

The late Lord Campbell said to three intelligent physicians, "you may go home to your patients, and be more usefully employed there than you have been here!" An equally learned judge said of another doctor, who was well qualified to give good evidence, "you might as well have staid at home and attended your patients." A Vice Chancellor of the Empire stated "that his experience taught him there were very few cases of insanity, in which any good came from the examination of medical witnesses. Their evidence sometimes adorned a case, and gave rise to very agreeable and interesting scientific discussions; but, after all, it had little or no weight with a jury." All judges do not sneer in the same manner, nor indulge in irony and sarcasm at the expense of the medical profession, but the weight given to a physician's or a surgeon's testimony is not commensurate with his capability to give intelligent and experienced medical opinions. I can see, however, indications of a better understanding between medicine and law. The study of the obsolete is giving place to the practical, and metaphysical distinctions, to pathological conditions, in considering many of the exciting causes of human conduct, coming under the head of jurisprudence. It will be seen how medicine and law are considered from different stand-points, and as a consequence the conclusions are diametrically opposite to one another. Medicine holds that all insane persons are afflicted with bodily disease. Law says this is not always the case. Medicine draws a necessary line between idiocy and insanity—the one being congenital, and the other pathological. Law says they are

one. Medicine declares that insanity, being a morbid state, no layman can properly pronounce judgment upon a patient's condition, nor in respect to facts that rise therefrom. Law asserts that a jury can, and should decide on the mental condition of the insane, based upon personal observation, just as an ignorant man would pronounce on the kind of disease a person had, from appearances alone. Medicine can show from living examples that the sense of right and wrong, the possession of delusions, and many other tests propounded by the disciples of Coke and Blackstone, can have no value to discover insanity, when taken alone, for many insane have a keen sense of the former, and many not insane are troubled with the latter. Law says possession of the first is evidence of a sound mind, but the presence of the other shows insanity. Medicine extends the hand of charity to the mentally diseased, and asks that such be kept in durance for the purpose of cure or safety to themselves or others. Law applies its iron-clad tests, and punishes all who can not pass the crucial ordeal. Medicine seeks after causes of action. Law deals out justice on the ground-work of appearances. Experts are called into court to testify in cases requiring the special aid of knowledge in chemistry, mechanics, or any other branch of science and art, and such testimony is accepted in its entirety; but medical men who make a special study of mental diseases, must have their opinions measured by the mental capacity of twelve jurymen, or worse still, by the dicta of judges, who accept rules laid down a century ago, when medical research was still in its infancy. Germany, France, and many of the States of the Union have accepted the medical basis of proof. It is expected that the British and Canadian courts will not ignore a system, that in every day practice will be found to be none

the less effective in punishing the guilty, while it will save many a poor wretch from the infliction of a punishment which he had not deserved, as an irresponsible being, any more than a child unborn.

Judge Doe, of New Hampshire, in addressing the jury, *State vs. Pike*, says:

"The legal profession, in profound ignorance of mental disease, have assailed the superintendents of asylums, who knew all that was known on the subject, and to whom the world owes an incalculable debt, as visionary theorists or sentimental philosophers, attempting to overthrow settled principles of law; whereas, in fact, the legal profession were invading the province of medicine, and attempting to install old, exploded medical theories, in the place of facts established in the progress of scientific knowledge. The invading party will escape from a false position, when it withdraws into its own territory, and the administration of justice will avoid discredit when the controversy is thus brought to an end."

Judge Wharton, in his work on "*Criminal Law*," says:

"No jurymen, if properly tender of his conscience and of public opinion, will base his verdict upon other evidence than that of those best able, from long training, and close attention, to understand the features of the case. In some cases the difference between a scientific, or technical opinion, and that of a layman, is not so much in the results attained, as in the guarantee afforded by the superior attainments and more minute expertness of a man of science. The declaration of such a man is insured against the possibility of error to the full extent of the protection of science in its present state of development. *Pro foro*, this degree of certainty is sufficient, because it is the highest attainable; but, the same can not be said of any other."

I make these few general observations to show that our position in court would be much improved did caution, consistency, discretion, good judgment and candor prevail to a greater extent among ourselves. This would more readily be the case were all medical

men, who might be subpoenaed upon a case, to meet together before being called as witnesses and in a calm, judicial way, discuss the different medical points bearing upon the approaching trial, and then go into the witness box, not as partisans "coached" for the occasion by counsel, but as unbiased witnesses, who "nothing extenuate nor set down aught in malice." These qualities are needed very much in the witness who gives evidence in cases of insanity. In most of such cases found on the criminal docket the disease is obscure, and to "make haste slowly" is very necessary, that judgment may be just. The defendant may be a malingerer or a monomaniac, who cunningly hides his peculiarities, as many of them do. Such may be afflicted with melancholia, giving intelligent answers to questions, yet possessing homicidal or suicidal tendencies. The medical witness is often asked to give an opinion of the mental condition of such a person after a few minutes observation and conversation, or at most after one or two interviews of short duration. There would be no difficulty in doing this were a patient maniacal and indulging in all kinds of "fantastic tricks," but any one who has passed through the wards of an asylum knows that a very large proportion of the patients are not of this class. Visitors and grand juries often mistake patients for attendants, and *vice versa*. A few weeks ago an intelligent banker of Toronto wrote to me a letter beginning with these words: "The *housekeeper* mentioned to me yesterday." He had been a visitor to the ward every few days for weeks to see a sick friend; yet he mistook one of the most cunning patients in the ward for the housekeeper, and had been consulting him about matters connected with the patients. He was somewhat astonished when told that the *housekeeper* was at times one of the most intract-

able patients in the ward. A short time ago one of our city lawyers, who prides himself on his power to read almost intuitively the hieroglyphics of character, and who, in his own estimation, could tell an insane person at sight, mistook one of my clinical assistants for a lunatic, and commiserated him on his unfortunate condition. He afterwards came to me for information about "the poor fellow," as he had taken a deep interest in his forlorn and apparently hopeless condition. His pride had a fall when the truth came out. A prominent government official, not long since, mistook one of my most intelligent-looking attendants for a patient. I am prepared at any time to select say twenty-four intelligent attendants or citizens, and twenty-four patients out of Toronto Asylum, and present them to any court of law before our most eminent judges, lawyers and jurymen. They will be allowed to make the same superficial examination which is often accorded to medical men in similar circumstances. The selection of patients shall be made from paretics in the early stage of the disease, from those afflicted with remittent insanity, from the melancholy and taciturn, and from monomaniacs. The judgment given of the mental condition found in each case, by such an intelligent and acute Board of Examiners, would show in a comical light what a travesty of justice it is to ask, even an expert, to give an opinion of mental unsoundness, or sanity, after a cursory examination of a prisoner. About a year and a half ago I was called to attend the assizes in a neighboring county and asked to decide in a few hours the *mental status* of a prisoner, who had attempted to take the life of his neighbor by shooting him. The houses of the two parties were near together, being situated on opposite sides of a country road. The prisoner cut a hole in the gable end of his house, and being a bachelor living

alone, no one saw him cut the hole or shoot. He shot twice at his neighbor, the last shot taking effect in his lung, but not fatally. Every one of the prisoner's acquaintance, lay and medical, thought him eccentric, but perfectly sane. The first two interviews I had with him, I was led to suppose the same. He could talk intelligently on every topic of conversation that was introduced, but would give no reason at first for the attempted homicide. At the last interview I had with him we began to discuss religious matters. Suddenly he asserted with great solemnity, and with a request to keep it a secret, that he was more than human. I suggested that possibly he might be God in human form. He asserted that I had found out the truth. He was omnipotent, and consequently could do what he wished. He had often lived sixty days at a time without food, to show that Christ's fasting of forty days was not a miracle. When he got out of gaol he intended to fast a year. He had been shot at with bullets by his enemies as he went along the road, or worked in the fields, but having an immortal body they could not harm him. We were sitting on a bed and I suggested that he might be smothered to death, but he said that he could live without breath. If his head were cut off it would not affect him. He could make himself invisible whenever he pleased. Every one's life was in his hands, and the wife of the man he shot was his by his divine right to her. Here it will be seen that a morbid idea led to the attempt at homicide. Had I not happened to touch the key that opened the door to this chamber of fantasies, these aberrations would not have been developed. I was subpoenaed by the Crown, but the Queen's council knowing that my opinion would be that this man showed evidence of insanity, I was not put in the wit-

ness box. The defence had not sufficient acumen to see that this refusal to examine me by the prosecution was presumptive evidence of my opinion being inimical to the case of the Crown council. The prisoner was treated as a sane man and a criminal. He is now in the Penitentiary Asylum. This case is cited to show the danger of hasty conclusions in cases of insanity, and the difficulties medical men have to contend with when asked to decide the mental condition of a prisoner at a few hours' notice. What shall be said of the jury who must give a verdict based upon conflicting opinions, and not upon personal knowledge of the condition of the accused? Some time ago the Commissioners in Lunacy in Britain wisely recommended to the government that "If, upon the occasion of the trial of an indictment, the plea of insanity be set up, we are disposed to think that the question should be tried and determined by the court after taking medical and other evidence, and not by the common jury to try the facts."

An eminent English expert (Bucknill) says:

"Generally the physician giving evidence can almost say that he paid *two or three* visits to the accused, and conversed with him in his *cell* in prison. In case of concealed delusions, or of disease affecting the propensities, no medical man ought to give an opinion on such shallow grounds. I am not ashamed, he continues to say, to acknowledge that I have observed patients *daily* for *several weeks* without being able to detect existing delusions."

The Court has too high an estimate of the discerning power of the members of the medical profession. It must be remembered that there is no well-defined line between sanity and insanity. No man can tell where the one begins and the other ends. That belongs to omniscience, for we can only infer from manifestations what are the pathological conditions of the brain, and mental disturbance consequent therefrom. A witness

should never give a positive opinion in obscure cases, for it must be remembered that while it is unjust to punish an irresponsible person who breaks the law, it is also not desirable that a cunning scoundrel should escape the just penalty of his crimes under a false plea sustained by medical evidence. We are not allowed to state as to a man's responsibility. The Court decides that important point. Here lies a wide gulf between law and medicine, and, because of its existence, truth has suffered. No formula can cover all the phases of insanity, nor can a measure be found that is sufficiently accurate to map out the boundaries of responsibility, and say to it "hither shalt thou come and no farther." All the conditions, physical and mental, of each individual must be known before the springs of action can be gauged with certainty in the shadowy borderland of insanity. "Is there insanity?" asks the Court of the medical witness. "Is he responsible?" is an enigma for the judge and jury to solve.

Bucknill, in his monograph on Lunacy, quotes a vigorous writer in the *London Times* on this point:

"Nothing can be more slightly defined than the line of demarkation between sanity and insanity. Physicians and lawyers have vexed themselves with attempts at definition in a case where definition is impossible. There has never yet been given to the world anything in the shape of a formula upon this subject, which may not be torn to shreds in five minutes by any ordinary logician."

Make the definition too narrow, it becomes meaningless; make it too wide, the whole human race are involved in the drag-net. In strictness, we are all mad when we give way to passion, to prejudice, to vice, to vanity; but if all the passionate, prejudiced, vicious, and vain people in this world are to be locked up as lunatics, who is to keep the key of the asylum? As was very fairly observed, however, by a learned Baron

of Exchequer, when he was pressed by this argument, if we are all mad, being all madmen, we must do the best we can under such untoward circumstances. There must be a kind of rough understanding as to the forms of lunacy which can't be tolerated. We will not interfere with the spendthrift, who is flinging his patrimony away upon swindlers, harlots and blacklegs, until he has denuded himself of his possessions and incurred debt. We have nothing to say to his brother madman, the miser, who pinches his belly to swell the balance at his banker's—being seventy-three years of age and without family—but if he refuses to pay taxes, society will not accept his monomania as pleadable at the bar.

Dr. Forbes Winslow, in his "Anatomy of Suicide," says:

"A man may allow his imagination to dwell on an idea, until it acquires an unhealthy ascendancy over his intellect. Surely, if under such circumstances, he were to commit a murder, he ought to be held as a murderer, and would have no more claim to be excused than a man who has voluntarily associated with thieves and murderers until he has lost all sense of right and wrong; and much less than one who has had the misfortune, of being born and bred among such malefactors."

This wide definition could not be of practical benefit, because bias, confirmed habit, hereditary wickedness, oddity and peculiarities, may be normal and the natural out-crop of successive voluntary acts by our progenitors or ourselves. In other words they are not the products of physical or mental disease, and are more or less the inheritance or acquisition of every one. This law of interpretation would include a large number of the insane as responsible beings. There are times in the lives of many lunatics when they not only know right from wrong (the distinctive Shibboleth of so many judges to the present day), but also when they can refrain from

wrong doing, for fear of punishment, as rational beings do in every day life. They can curb the insane impulse by volitions which are within their control. Should they be exempt from penal consequences? The asylums are full of inmates, who for weeks together, are—as far as human knowledge goes—comparatively sane. Their insanity is periodic. In the intermissions of sanity such have full control over all their acts, and are cognizant of their relationship to society. The equilibrium of the mind at such times, as far as we can judge, is maintained, and such are quite capable to transact business, to bear injuries with equanimity, and forbear from any overt acts as any perfectly sane citizen. If at such times, and during such intermissions the individual commits a felony should he be held responsible and punished for his crime? I am well aware that objection may be raised that during these so called “lucid intervals” the mind does not fully recover its normal tonicity. This may be true to some extent in many cases, but if the mind have not all the strength of a totally sane man, in vigorous mental health, it has sufficiently recovered, at these times, to perform all its necessary work in the same manner and within the same control as the great majority of mankind. It is proposed to medical men, in view of these difficulties, to confine the definition of insanity to mean brain disease. In this way the question of responsibility would still remain with the Court. If by disease is meant organic lesion, then would the definition be too limited; for functional derangement will dethrone reason for a time. This is seen in the inhalation of anæsthetics, in drunkenness, in the wild delirium of fever, and in the effects of many other toxical agents. The brain may become affected functionally, because of excitement in one or more distant organs of the body. This is seen in the klepto-

mania of women at certain menstrual periods. The woman who revels in wealth will become a thief at such times, who would revolt at the thought when the frenzy passes away. It is the love of stealing, not the pleasure of possession alone, that prompts the act. We see the same eccentric causes in puerperal mania, at the climacteric of female life, hysterical mania, nymphomania and such like, which may in their initiatory invasion be excitants and the cause of permanent lesion of the brain in the long run, but none can say that the mischief has not begun outside of the brain. Disease of the brain will cover the large majority of insane. Disease of the body, outside the brain, will show an efficient cause in many. The two combined make a good majority in our asylums, but to say that lesion of the brain only is a complete definition of insanity would not be in accordance with experience. *Post mortems* often show extensive adhesions inside the skull, and serious invasion of disease in the substance of the brains of those who have died of other bodily diseases, but sane to the last. Also many an insane person dies and leaves no evidence of mischief in the head. The exciting cause may affect the encephalon from without, or it may be beyond the research of the pathologist, and can not be a basis to support the definition above given. Even if this definition were correct, it would be impossible to state when it existed except by mental and physical manifestations; then why not accept a formula like that of the German Penal Code, viz.: "An act is not punishable when the person at the time of doing it was in a state of unconsciousness, or of disease of mind, by which a free determination of the will was excluded." This does not reject the idea of bodily disease, but it takes the outward manifestation as an indicator of the mischief

within, just as the hands of a watch point out the condition of the machinery within. It is a question of *will not* and *can not*, of voluntary or involuntary action, or, in other words, had the accused in any particular act sufficient mental strength to control his actions at any time he wished, or was he led blindly and irresistibly, from any cause, to conduct unnatural and unusual for him to do? Properly speaking none are absolutely free. Inherited predisposition, educated bias, confirmed habit, hobby-riding, well-fed ambition, and such like, are manacles to impede volition. The free will of a sane man must always be considered in a modified sense, for the ball and chain are hanging at our limbs, as we are paying the penalty for the transgressions of ourselves and ancestors.

The medical witness is to remember, however, that it is not his province to give a general definition of insanity. He is often entrapped into an attempt to do this, in order to give a council an opportunity to hold him and his opinions up to ridicule. He is asked in derision, "what is insanity?" but he can retort by demanding the catechist to define one of the terms of his own question. The discussion of insanity, in the abstract, must be left to essays and text-books. Only facts and legitimate opinions, deduced from them, are asked for to enable the Court to decide for itself, whether they are such as to warrant the plea of insanity on behalf of the person under consideration. The witness is to guard against being led into defining the insanity of any one, as being a want of power to distinguish *right* from *wrong*. True, many insane people have not that discrimination, but on the other hand, a large percentage of lunatics have that power, as fully as the sound in mind. No jurist, who has the slightest experience of insanity, now holds that view, because it

flies in the face of accepted facts. An illustrious race of English judges, for centuries past, and down to this hour, pronounce verdicts based on this inadequate judgment. On examining recent charges to the juries of Canada, I see indications of change of opinion, in this respect, among our judges, which are more in keeping with the truths of modern investigation.

In the Toronto Asylum there is an estimable lady, who is afflicted with religious melancholy. She has made several attempts at suicide. She never loses her sense of "the wickedness of the attempt," as she calls it, but the uncontrollable impulse is too strong for her. On one occasion recently she felt the strong desire coming on, and begged to have the leather muff put on her hands, lest she might be forced otherwise to accomplish her design. The courts would hold her to be an accountable being, seeing the sense of right and wrong had not been extinguished. A powerful mulatto is in the refractory ward, who is constantly persecuted with spirits. He has, intermittently, a longing to kill somebody. He knows it is wrong to even think so, and at these times he asks the supervisor to lock him in his room. According to the interpretations of law, should he commit homicide, he ought to be hanged. In another ward is a patient, who was at one time a prominent writer for the press. He is afflicted with chronic mania, of the most pronounced kind. On a recent occasion he told me that he "felt like wanting to kill" one of the patients, against whom he had taken a dislike. He said he knew it was wrong to think so, but cunningly added, "you know I am crazy so they wouldn't hang me." If, unfortunately, such homicide should take place, he should be hanged according to law. Dozens of such cases could be cited in any of our asylums. Dr. Hammond, a reputed expert on insanity, an extensive

writer on the subject, at one time Surgeon General of the United States Army, and now associate editor of *The Journal of Nervous and Mental Disease*, said recently in a discussion which took place on this subject, at a meeting of the "Medico-Legal Society, of New York," "that he is in favor of punishing insane people, just as he would a tiger who went about destroying people. If a lunatic had a homicidal mania he would hang him."* He would not only hang *any* and *all* insane people who killed any one, but he would hang them if they had a mania to kill, even were the deed not performed. This would be an effectual way to make vacancies in our asylums, and would remove perplexing problems from courts of law to the scaffold and the grave. I am sure such a brutal idea will never prevail where humanity exists. One of the theories of the transmigration of souls was, that some one died when each mortal was born, and the soul of the dead one was immediately translated to the new-born child. I am afraid no one died when Dr. Hammond was born. I take this charitable view of the author of such a horrible proposal.

There is reason for caution in a witness, when he is asked to acknowledge that peculiarities of mind may mean insanity and irresponsibility. A man may do a great many strange things, and still have perfect soundness of mind. There is no common standard to measure mentality with, analogous to the yard stick and bushel in the British Museum. Each man must be gauged by himself, in his antecedent conduct and individuality, for among all the sons and daughters of Adam, no two are alike in body and mind. No man can be justly tried by a code of laws, which indulges in vague generalities, on the one hand, or which vaunts an absurd, minute classification on the other. What

* *The Journal of Mental and Nervous Diseases*, July 1878, p. 556, et seq.

may seem odd in a naturally quiet and reticent man, may be the usual conduct of him who is "boiling over" with exuberance of spirits. The temperament, peculiarity, bias, habit and mode of thought, of each person must be considered in relation to each history. To expect uniformity in humanity, and judge that one man must act like any or every other man, is the greatest absurdity. This want of sameness must forever bar the way to finding a general definition of insanity. The conditions are too multifarious for us ever to prove mental *status*, with formulæ as definite as those of Euclid.

A witness should not allow himself to be led into a trap by having proposed to him one symptom at a time, and then be asked if each of those indicate insanity. Each symptom might not be characteristic in itself, when the aggregate might be conclusive. When details are asked for the witness must guard himself by insisting on their accumulated weight, to enable him to form an opinion. This may not be necessary in acute cases, when the patient's actions speak louder than words, but the sum total of symptoms is of great importance when the indications are obscure. Many times it is impossible to express, in words, the gait, mode of expression, look and general demeanor of an insane person, so as to impress a court with their forcible significance. Take an example of one of many found in any asylum. A person was once tidy in his habits; is now slovenly. He had a firm step; he has now a shuffling gait. He never decorated his person; he now makes a ring of some material for his finger, or ties it in a button-hole. He was not a keen observer of small things; he now notices and picks up pins, nails, straws, bits of glass, or any other small object that may come in his way, placing them in some corner,

in his pocket, or in any other part of his clothing. He may have had distinct utterance; but he has lost that clear enunciation of words and mumbles them out. He was inquisitive, at one time, as to what was going on around him; he may now listen to a recital of stirring events, and take a momentary interest in them; but it is of short duration. He was active and industrious; but he is now lazy. This recital might be extended indefinitely, but, in short, there is a perversion of the patient's whole character. The medical witness sees a case of dementia, yet, each of the symptoms taken *seriatim*, would have no significance, being without salient points, to an unobservant jury, and even the combined catalogue, would have little force or weight in many courts of law. There may be no delusion apparent; there may be a sense of right and wrong. Sharp questionings may elicit correct and intelligent answers, but a number of changes of character, such as I have enumerated, pronounce an unsound mind; or rather that physical disease has instrumentally impeded the healthful exercise of mental vigor. The ancient aphorism holds true amid all the fluctuations of mental philosophy, *i. e.*, "a sane mind in a sane body." The appearances of disease may be faint, when taken in detail, but to a practiced eye, and to a matured judgment, accustomed to study the faintest outcrop of mental aberrations, those peculiarities tell a tale which may have no weight with the unskilled in the protean forms of insanity.

It is sometimes insisted upon that a categorical answer be given to every question put to a witness. It may be impossible truthfully to do this, because of the form in which the interrogation is put. The examiner is well aware of this fact, hence the bait cunningly thrown out to catch the unwary. For example, were it

asked about a patient, "Did he then refrain from speaking nonsense?" Were the answer "yes" it would imply that he had been speaking it, but had ceased to do so. Were the answer "no" it would mean that he had spoken nonsense, and continued to speak in the same strain up to the time under discussion. Neither answer might be true, for if the patient had not spoken at all, as indicated, the fallacy lay in an assumption which had no existence. It would be begging the whole question, and neither a positive nor negative answer could cover the ground. This is only one specimen of a legion of such questions which often perplex beginners, and are propounded with that object in view, and a negative or positive answer demanded with legal pertinacity. When such traps are set and baited with sagacious design, a state of "masterly inactivity" is best, until the questioner goes back to legitimate interrogation. A medical witness should never quote authorities, nor should he be entrapped into endorsing or refuting such, if they should be presented by council for his consideration. No published books on medical subjects are competent witnesses in court; nor is a witness compelled to give an opinion about the views the authors may advance. The writers themselves are the only legitimate persons who can testify to their theories and beliefs. I have often seen witnesses caught in this way, even before the opposing council could put a veto on the irregularity. "Do you agree with Maudsley in his view on this point?" "How does it happen that Bucknill and you differ in this respect?" "Can you give me Tuke's opinions on the subject under discussion?" "In Ray's Jurisprudence such and such theories are advanced, what do you think about them?" "You have read Taylor, will you state what he says about insanity in respect to competent wills, or suicide,

or homicidal mania?" These are specimen interrogations which may be put, but need not be answered. A refusal to do so will be sustained by the Court. If a witness begins to air his medical lore by quoting authors, he may be able to show his possession of a good memory, but he will not contribute any *facts* of which he is cognizant, through giving lectures on the opinions of others.

The most difficult position a medical man can be put in, is when called up to give evidence in cases of contested wills. The capacity of a testator to make a will and the soundness of mind requisite to make a valid one, are often questions of great difficulty. It should be held generally as essential that the testator should have sufficient mental capacity to comprehend perfectly the condition of his property, his relation to the persons who were or might have been the objects of his bounty, the scope and bearings of the provisions of his will, and a memory of an activity sufficient to collect in his mind, without prompting, the particulars or elements of the business to be transacted, and to retain them in his mind for a period sufficient to perceive at least their obvious relations to each other, and to be able to form some rational judgment with relation to them. (*Vide* Rokenbaugh on Testamentary Capacity, *Journal of Nervous and Mental Disease*, July, 1878.) This test will cover all the ground. It does not assert incapacity to eccentric testators, nor those who may be laboring under delusions of facts. Esquirol says: The brain may be affected, but it does not necessarily mean an impairment of the understanding. On the other hand, it was strongly asserted by Lord Brougham, and is now by certain class of thinkers, that *any* insane delusion entirely destroys the mental capacity of a testator to make a competent will. Lord Brougham

tells us that when travelling in the north of Europe he at one time was taking a bath at his hotel. As he came out of it he saw a friend in the room, who at that time had died in India. He says he became insensible immediately afterwards. This apparition was doubtless the premonition of a fit. His lordship would not have agreed to have the rule of incapacity applied to himself on account of this hallucination. Lincoln had many delusions, so say his biographers. Sir Walter Scott was not exempt from them, when he was in the zenith of intellectual vigor. Dr. Johnson heard his dead mother calling out "Samuel." Lord Castlereagh, the brilliant but corrupt statesman, often saw a beautiful child in his chimney corner. Goethe also positively asserts "that on one occasion he saw distinctly his own double"—or himself outside of himself. General Rapp tells us that Bonaparte saw a star of great brilliancy above his head. Napoleon said: "It has never abandoned; I see it on all great occasions; it orders me to go forward; and it is a constant sign of good fortune." Malebranch, Descartes, Luther, Wesley, Knox, Pascal, Loyola, and many of the most remarkable men of the past ages were the victims of all kinds of delusions and illusions. Yet, these children of genius could not be properly called lunatics, even if genius be said to be nearly allied to madness. There is no doubt, in my own mind, that all such deceptions of the intellect or senses often exist without mental aberration being present of sufficient intensity to invalidate a will.

"At the same time in the consideration of every case imbecility, delusions, monomania, or hallucinations, intoxication, lucid intervals, undue influence or fraud, and presumptions arising from the character of the act itself, the age of the testator, and such bodily infirmities as deafness, dumbness or blindness," must be well

weighed in considering testamentary capacity. Eccentricity is said to be the lowest form of insanity. It is seldom, however, that a will is made invalid because of its existence in the testator. In 1861, a wealthy Portugese died in Paris. He left a will with seventy-one codicils. One of which read "I leave for the Athenæum of Paris 10,000 francs, and the half of the interest shall be paid to a professor of natural history, who shall lecture on the colors and patterns of dresses and on the characters of animals." Another was, "My funeral shall take place at 3 P. M., the hour at which the rooks of the Louvre come home to dinner." The will was held to be valid, the Court saying "that these peculiarities were but the absurdities of a vain man." The peculiarities of the eccentric are as varied as are the phases of the mind, and it has been well said by Redford, in his "Treatise on Wills," that "The *eccentric* man is aware of his peculiarity and persists in his course from choice and in defiance of popular sentiment; while the *monomaniac* verily believes he is acting in conformity to the most wise and judicious counsels; and often seems to have lost all control over his voluntary powers, and to be a dupe and victim of some demon like that of Socrates."

Without entering into details, which would need a volume to elucidate fully, it is well in every case to consider whether the aberrations are such as would warrant us to sign a certificate of insanity to commit to an asylum for treatment and safe keeping. If we do not consider such to be safe at large, they are not responsible beings. We should examine as to delusions and ascertain if they are sufficiently strong to warp the judgment and seriously affect the conduct of the individual; or, if they are of such an insulated nature as not to interfere to an appreciable extent with volition,

and are not joined with morbid emotions and sentiments. It is also important to observe if the moral feelings and passions are perverted, if measured by a common standard, or better still by the patient's former temper and character, and if these are sufficiently morbid to affect the power of self-control. The impulsive form of insanity is to be examined with great care, for under its guise real culprits take shelter to avoid just penal consequences. The strongest evidence of its existence should be made manifest to a medical witness before he testifies to the presence of mental disease in such cases. If these cardinal points are kept in view, an aid to intelligent testimony will be the result.

APHASIA, OR APHASIC INSANITY, WHICH? A MEDICO-LEGAL INQUIRY.*

BY DR. C. H. HUGHES, ST. LOUIS, MO.

On the 13th day of March, 1873, Mr. Wm. T. Bevin, a few months after the death of his wife, was stricken with right hemiplegia and aphasia. A cardiac valvular lesion preceded the paralysis and is still persistent. At the time of my last examination, February 7, 1876, I found his respirations, without discoverable pulmonary lesion, to be twenty-one per minute, and the heart and wrist pulsations asynchronous, the latter counting as high as one hundred and eight, and the former sometimes ten to eighteen more, per minute. At this time there was incomplete paralysis of motion on the right side and general anæsthesia. He was insensible to the pricking of a pin in both hands and feet. The sublingual temperature, on either side, was 96° F. He correctly and promptly comprehended oral signs, but tardily and imperfectly understood written ones. He soon recognized my name and wrote it for me, with his left hand. He likewise wrote his own name and the surname of his attorney (Mr. Rainey), upon my asking them. An H, written by myself, and an imperfectly erased tracing of my surname, were on the card on which he wrote my name. He first attempted to attach "ughes" to the H, I had written, but afterwards changed his mind and made an H of his own, which

* Read before the Association of Medical Superintendents of Asylums for the Insane, at Washington, D. C., May 17th, 1878.

accounts for the somewhat disjointed appearance of the word Hughes:

Ch H Hughes

His tongue was clear, but he said he always had a disagreeable taste in his mouth. He either really had, or feigned, defective vision. When the thumb was held up before him, looking with one eye, the other being blind-folded, he would say it was two, and when the thumb and little finger were held up, he would say they were three. I intended making an ophthalmoscopic examination, but before I had opportunity the case came to trial,* and my testimony not being satisfactory to the family, I did not offer to examine him further. He either had defect of hearing in the left ear, or feigned it. I could not certainly determine which. He signed that he could not hear the ticking of a watch half an inch from his ear, yet he distinctly understood a remark addressed to him by his sister in quite an ordinary tone, at least twelve feet off from him, at the time I was testing his hearing. None of the family spoke to him in a very high tone, as is customary when one is deaf. He repeated the word *nin-nin*, accompanied by a nod of the head, to signify yes and by a horizontal turning to indicate no. When I wrote W. T. Bevin and asked if that was his name, he shook his head and taking the pencil wrote Wm. T. Bevin:

Rainey
Wm T Bevin

* William T. Bevin vs. Powell et al. Circuit Court No. 2, October Term, 1878.

He had three paralytic strokes, and was seen by his relatives after each attack. He has grown steadily better, and they now regard him as perfectly rational, but considered him unsound of mind on the fifteenth day of July, 1873, four months after his first seizure, when he signed with his left hand a deed of trust of his portion of some houses he was building jointly with some other parties, and in fulfillment of a promise and purpose, made and entertained prior to his attack. He could not write with his left hand before he was stricken. About the time of, and prior to the signing of this deed of trust, he is said, by some of the members of his family—principally his two sisters and a brother-in-law with whom he lived and is now living—to have done some things which they swore they regarded as evidences of insanity, such as on *one or two occasions* (none of the witnesses testifying to more) bowing to pictures in the parlor, when he knew members of the family were present, and with a pleased, but silly smile on his countenance. Once he is said to have wiped his nose on his napkin, and once or twice, in the early stage of his paralysis, they say he spat on his plate. Once he unbuttoned his drawers when his sister and another lady were in the room. It was said that once, shortly after his first stroke of paralysis, he defecated in bed. Once, he is said to have struck his mother with a stick, though one of his brothers, who swore there would have been no suit if he had got his three per cent commission, as promised for taking his afflicted brother's place in conducting the work, never saw or heard of his bowing to pictures, striking his mother, or unbuttoning his drawers.

Some time in the June following the stroke of paralysis, he recognized and pointed at the picture of the crucifixion, and other objects when asked to point them

out. At this time he could not, the family say—all but one brother—distinguish letters or tell if they were upside down or not, but readily recognized them if their names were called. As early as the first of May, 1873, he could sit in a chair and get about the room. In June he appeared to one of his physicians to be silly, "because he smiled peculiarly" and was exceedingly violent and irritable when the battery was applied. To another of his physicians he appeared demented, though he was able to go unaccompanied in the following November, a long distance to this physician's office, correctly select and count his money and pay his medical bill, and take and put away carefully a receipt for the same. It was said also that he made grimaces before a glass once or twice, and pulled out his hair, and he ate things, when set before him, that he never ate before. He handled his food with his fingers (he could not use a knife and fork), and his manners and tastes at table were changed in some other respects, he having been formerly very fastidious and precise.

When he first learned to write his name he would make signs to visitors for a slate, write his name for them, and express his pleasure at the accomplishment by a peculiar smile. After the description of his property, mentioned in the deed of trust, was read to him, he pointed in the direction of it and gave an assenting nod, pointing immediately after in the direction of other property not alluded to in the document, and indicating his understanding that it was not included, by the usual turning away of the head indicative of dissent.

He was attended by different physicians during the first attack. The physician who first saw him at the time of his first seizure found him only partially paralyzed on the right side, with consciousness still remaining, and helped him home. In six hours

after this physician saw him, he was hemiplegic and unconscious, and so remained for several days. He commenced to improve in two or three weeks. He was then annoyed by movements about the room and exhibited "not much, but some signs, of intelligence in his countenance." He made signs and efforts to convey ideas, and would mumble unintelligibly in answer to questions and had difficulty of deglutition. He never, at any time, had *delirium, delusion or hallucination*. He recognized Dr. Mudd generally when he visited him. One attending physician thought his mind was impaired, because "there seemed to him to be an absence of the power of expression and clear conception of subjects." This was just after the stroke. This mental confusion was a natural concomitant of the great *commotio cerebri* incident to such a severe, extensive and sudden involvement of a cerebral hemisphere in disease, even though that disease were solely at its base, which was here not the case. He might, at this stage even, have been demented, as he was considered to be, later, by one of his physicians but it could not be the real and permanent dementia which results from general degeneration and destruction of the cerebral cortex, as the improvement which soon began to appear and all the sequelæ—his learning to write with his left hand, recognizing and designating friends, pictures, etc., within four months, conclusively proved.

When we reflect that his hemiplegia embraced one-half of his face, in paralysis, it is not strange that he should have appeared silly and smiled peculiarly in May. His being irritable and violent when the battery was applied at that time, indicates only that the degree of paralysis of sensation has increased since then. It is not strange that he could not distinguish letters or tell if a book or paper were upside down, confusion of

vision being the rule rather than the exception, after hemiplegic strokes. The great length of the *tractus opticus*, and of the optic nerve within the brain, and the manner in which they are supplied with blood vessels, expose the apparatus concerned in sight to great disturbance of function from pressure, etc.; for this reason disturbances of vision are common in morbid conditions of the brain. This patient might have been totally blind from pressure consequent upon the cerebral oedema, which generally follows embolic closure of a vessel in other parts of the brain than the spot primarily implicated in the thrombosis, if we take no account of possible similar, simultaneous closure of other arteries of the brain. We have but to remember how closely related are the nuclei of the two optic nerves, in the *corpora quadrigemina*, to see how easily double impairment of vision may result, at least for a time, from a cause sufficient to engender hemiplegia.

In regard to dementia, which only one of his physicians asserted that he had (Dr. Benkendorf), it is difficult for the practiced alienist, accustomed to observe the phenomena and progress of this profound form of mental disorder, to conceive how a patient could have really been demented in June, in consequence of a cerebral vascular lesion grave enough to cause hemiplegia, paraplegia, confusion of vision and aphasia, and yet, be so recovered by the next following November, as to fully appreciate the services he had received from his physician, and go unaccompanied to his office, and settle in an intelligent manner his bill, even though he could not speak.

It was singular that of all the acts testified to by Bevin's brother-in-law and sisters, who were living with him and interested in the success of his suit, none of them should have been observed more than

once or twice during the whole time of his affliction. Many of these acts, had they occurred oftener, would have been explicable otherwise than on the theory of insanity, and all of them, as the testimony gives them in this case, are explainable without invoking the presumption of insanity, though a medical gentleman of practical experience with the insane, for whose opinions I have a high regard, and whom the courts justly recognize as an expert in questions of sanity, thought these acts indicated mental incapacity on the part of Bevin. Another medical gentleman of large practical experience with the insane, no less eminent in psychiatry before the courts and in my own esteem, concurred with me in the opinion that these acts occurring before the signing of the deed—some of them, as the bowing to pictures, etc., within a month or two—did not indicate sufficient mental impairment to disqualify him for a full appreciation of the nature, quality and purport of the transaction.

In this case, I think, there was undoubted mental impairment to the extent at least of a crippled power of expression. There was impairment of executive mental power to such a degree as to incapacitate the individual from profitably engaging in the pursuit of his avocation, after he had finished up the business which occupied him before his affliction. Mr. Bevin seemed himself cognizant of this fact, and conducted himself after his affliction strictly in harmony with his surroundings, and does so still. He learned to write his name with his left hand, attached his signature to an important document, as it was necessary for him to do in order to complete the undertaking he had been engaged in, and after that signed no more documents, nor attended in person to any business, but relied on the proxy of his next friend.

Let us look at his acts and see how far they tend to establish insanity. In the first place they are *limited in number, not a single habitual action* appears in his history that is at all singular. He defecates *once* in his bed *at the time it is testified by his family physician that he is paraplegic*. This was more likely an accident due to his paralyzed condition at a time when no one was present to assist him than the result of mania. No one was present at the time it occurred. Maniacs have often filthy *habits*. Accidental occurrences of this kind are seldom, if ever, observed. The *spitting in his plate once or twice* before he had learned to so co-ordinate the muscles of oral expulsion, or to adapt his position at the table to the changed circumstances of disease, was due to the facial paralysis rather than insanity.

Then as to his irritability. Recovering paralytics are known to be irritable, and not very reasonable at all times when irritated. They can not make their many wants understood, and while they understand themselves well, can not well understand why those about them do not comprehend their gestures and grimaces more readily. That he should once strike his mother, under such circumstances, does not then appear as an act of insanity. He was at that time an irritable, childish paralytic, but gradually improved, and never struck her again. He would not have struck her after he had sufficiently recovered to write his name with his left hand. He never attempted to strike anyone then.

In regard to the *bowing to pictures* which he had not seen since he was stricken and carried to his bedroom a helpless paralytic, it would have been more singular if he had not, when taken into the parlor, the first time since his affliction, have sought to indicate in some way to his friends that he recognized the objects about him. This act showed an appreciation of his

condition not common to insane people, and a desire to impress the fact of his mental improvement upon those about him, just as did the frequent calling for paper or slate and pencil, writing his name, and showing them to visitors with manifestations of pleasure on his countenance, even though "his smile looked silly." If he smiled at all it must have been a silly looking smile, by reason of his physical facial disability. How could a hemiplegic face put on a beautiful or intelligent looking smile? If, smiling, or in mental repose, his face had even habitually shown the *risus sardonicus*, this would not have proven him mad.

The motive for the making of grimaces before the glass, and pulling out his hair once or twice, does not appear in the testimony; nor does it appear that he had no motive. A desire to discover to himself the degree of muscular facial paralysis would not have unreasonably led him to view himself thus in a mirror, and move the muscles of his face, and chagrin at the disagreeable revelations reflected, might lead, without the concurrence of insanity, to the pulling out of some hair. It does not appear that he pulled out much hair, or that he often repeated the operation. I have seen the insane pluck out every hair of the head, and repeat the process, allowing no single hair to remain. It is unusual for an insane person to pull once or twice at his hair and never repeat the operation. It is not common for an insane person to go to a mirror for the purpose of plucking out the hair, and going to a mirror for the purpose of making grimaces is certainly an anomaly among the insane. There is too much of rational motive in it. It is too much like desiring to see how it looks. And this was Bevin's motive. He wanted to see how he looked, and what muscles of his face were still paralyzed. This would be only a rational proceeding on the part of any man convalescing from a para-

lytic stroke, which had involved, and still to some extent, implicated his face. It is possible that insane persons, under the dominion of a delusion, might go before a glass and pull at their hair, though not usual, but no delusion appears in this case, in this connection, or in any other relation. I have seen my own son study the play of his facial muscles, and when I was a student of anatomy I did the same thing, before a mirror too.

The circumstances connected with wiping of the nose on the napkin or table-cloth do not appear. He wiped his nose once or twice. It was not shown that he had a pocket-handkerchief, or that he had never used his napkin in lieu of a handkerchief before his affliction, or that he did not do it to annoy, rebuke and chagrin those who should have given him a handkerchief.

Laying aside the reasonable presumption made by one of the attorneys, that the testimony to the outrageous and indecorous acts detailed, was the prejudiced evidence of interested relatives, enjoying the benefit of the property placed in jeopardy by the suit, I did not believe this man to be *non compos mentis* for the transaction in which he was concerned, because—

First. The paralysis alone was sufficient to account for most of his acts, his improvement and gradual recovery for the remainder; he being now sound in mind and able to go about with no affliction save the aphasia.

Second. Because the lesion was one involving but a portion of one hemisphere of the brain. Atrophy or destruction of a whole hemisphere, especially if gradually brought about, not even necessitating mental disease, the sound hemisphere being capable of vicariously supplementing the one diseased, in the performance of the mental functions.

Third. The grey matter, even on the affected side, seems not to have been greatly involved, as shown in

the absence of incoherence, delirium, delusion, illusion or hallucination, during the whole progress of the case, and retention of memory, and ability to learn, *for a purpose*, to write his own name, in a few months after the stroke, with his left hand.

Fourth. With the absence of incoherence, delirium, delusion, etc., there was marked involvement of the face and extremities, absence of muscular twitchings in the limbs, and of rigidity of the neck and other parts of the body, which usually accompany paralytic lesions involving also the *cortex cerebri*. The lesion was mainly an obstruction of the left middle cerebral artery at the base of the brain, as revealed by the *aphasia* and gradual coming on of the paralytic attack.

Fifth. The nature of the lesion with the part of the brain mainly implicated in this case, is one from which persistent intellectual aberration seldom results; the equilibrium of the disturbed cerebral circulation being soon re-established, even when the circle of Willis is obstructed, instead of one of its branches, as in the case before us; and—

Lastly. For a reason which some may not deem of any weight, namely, because that portion of the brain which has to do, in all probability, with the highest intellection, is the posterior lobes of the cerebrum, and they are not nourished by the artery mainly concerned in the lesion before us; “a conclusion which, however contrary it may be to generally received opinion,” to use the language of Charlton Bastian, “has been strengthened by observations made independently in different directions, and by different persons. It seems to agree, moreover, with clinical and pathological evidence,”* Dr. Hughlings Jackson and other authorities on the subjects of brain disease agreeing with him.

* Bastian on Paralysis, from Brain Disease, p. 239.

FEIGNED INSANITY, HOMICIDE, SUICIDE. CASE OF WILLIAM BARR, *alias* BALL.

BY CARLOS F. MAC DONALD, M. D.,
Superintendent of State Asylum for Insane Criminals, at Auburn, N. Y.

Since the first recorded attempt to simulate insanity was made by Ulysses, who, according to fabled story, lived 1190 B. C., it has frequently been the province of medical jurisprudence to distinguish between real lunacy and the more or less dextrous imitations attempted by individuals seeking, either immunity from obligations of various kinds, or, to escape from punishment for the commission of crime; the latter, no doubt, from the nature of things, being by far the most frequent motive for such attempts. When we recall the fact that, in its infancy, psychological medicine was surrounded with vagueness and superstition, we are not surprised that the idea that insanity could be successfully counterfeited by any ordinary individual, should have obtained in common with the then prevalent ignorance of the whole subject of mental medicine; but to one at all familiar with the present literature of the subject, it seems strange that the often quoted assertion of Zacchias that "there is no disease more easily feigned, or more difficult of detection than insanity," should be accepted, at the present time, as a truism, by certain portions of the community, including not a few medical men; and yet almost all modern medical writers whose opinions, by reason of their practical knowledge of insanity, are entitled to weight, are agreed that insanity is not easily feigned, and consequently that attempts at simulation can not long escape detection when carefully scrutinized by those who are qualified

to expose them. It is said that Dr. Rush was able to distinguish between feigned and real lunacy by the condition of the pulse, while Dr. Knight and others are said to have relied upon the presence, or absence, of a peculiar odor, which they claimed was invariably emitted from the persons of the insane. Cabanis, Cox and others, excluded insanity if they failed to find "a peculiar cast of countenance," which they regarded as typical, and furnishing an "infallible proof of mental disease."

While we would not wish to be understood as accepting the above mentioned tests as infallible, nor even as admitting that any one sign, or symptom, or method, may be relied upon for the detection of feigned insanity, we do feel warranted in asserting that, guided by the light of existing knowledge respecting the various phenomena of mental disease, and possessing a familiarity with its clinical aspects, the alienist physician, if afforded sufficient opportunity for investigation, can rarely fail to recognize the sham of lunacy. Says Georget: "A person who has not made the insane a subject of study can not simulate madness so as to deceive a physician well acquainted with the disease." Connolly declared that he could scarcely imagine a case which would not be exposed by an efficient method of observation; and Bucknill and Tuke say: "To deceive a skillful alienist who takes pains, patiently and fully, to investigate the case, the simulator of insanity must, if he displays any active symptoms, not only have carefully observed the symptoms of those who are truly insane, but be able himself to represent those symptoms, with powers of imitation which are possessed by few." Sheppard, in his "Lectures on Madness," when speaking of the feigner, says: "Commonly he does not know how difficult and sustained a part he has to play for

even a remote chance of success, and the curtain falls upon a grotesque and blundering farce more quickly than he anticipated," and again, "Those who are acquainted with the genuine article will soon discover how miserably he is over-acting his part, tear off the mask, and expose the imposture. Bear in mind that cultivated and refined malingerers, such as Shakespeare has depicted the Danish prince, are of very rare occurrence." Blandford regards it as fortunate that but "few know how to feign insanity," and adds that "the majority of simulators are clumsy performers," and can readily be detected by those who are in constant contact with the insane. Opinions similar to the above have been uttered by almost every prominent modern writer upon the subject of insanity. Deeming it unnecessary to adduce further evidence in proof of the difficulty of successfully feigning insanity, I now proceed to detail, briefly, the case whose name appears at the head of this article.

William Barr, *alias* Ball, a native of Ireland, single, and by occupation a peddler, was convicted at a Court of Sessions, held in the city of New York, December 16, 1870, (when he was twenty years old,) of robbery, first degree, and sentenced to State prison at Sing Sing for a term of ten years, and subsequently transferred to Clinton prison, where he remained until February 4, 1874, when he was transferred to the State Asylum for Insane Criminals at Auburn.

The prison physician's certificate, on which he was admitted to the Asylum, stated that while in prison he had been employed "mainly in the mines," that he was intemperate, that he had served a previous sentence of "one month in penitentiary for fighting," that "so far as known" he had suffered no previous injury or disease, that he was not known to have been insane before

conviction, that the then attack began "about April 1st, 1873," that the probable cause was "masturbation and use of tobacco," that he was "subject to excess of passion when irritated," that the form of his insanity was "chronic mania and melancholia without apparent lucid intervals," and that he had been subjected to punishment "in the Pulleys for fighting."

Unfortunately there is no official record of Barr's history during the period of his first confinement in the Asylum, but the Assistant Medical Officer and several of the subordinates who had charge of him at that time, stated that he was not regarded by them as insane, but as a vicious, depraved, quick tempered, incorrigible fellow, who was disposed to be quarrelsome on the slightest provocation, and who required "much restraint and punishment" to keep him under control; also, that he once cunningly effected his escape from the Asylum, but was captured and returned the same day. They further stated that the then superintendent frequently expressed the opinion that Barr was not insane,* and ought to be sent back to prison, and that he only refrained from sending him back for the reason that his vicious and troublesome conduct would probably serve as an excuse for his recommittal to the Asylum. He was, however, after remaining in the Asylum about two years, returned to prison March 1st, 1876, *as not insane*, that being among the last official acts done by the late superintendent.

Of Barr's history, from the time of his return to Auburn Prison, in March, 1876, until the following September, when he was readmitted to the Asylum, and first came under the writer's observation, nothing definite is known. The second certificate stated that he had "paroxysmal mania and melancholia," that he was

* This was testified to by Dr. Channing, at the trial.

able to work, was mischievous, and had been punished "in cell." The Asylum record shows that when readmitted his physical condition was good, "no bodily disorder observed." The following is a condensed transcript, from the case book, of entries made by the then assistant physician, who had observed Barr during the last seven months of his former confinement in the Asylum:

September 27th, 1876. Readmitted this day from Auburn Prison, to which Institution he was transferred from this Asylum as *not insane*, in March last, after having been under observation twenty-five months, during which time he showed a vicious, depraved disposition, but no insanity. His prison record is very bad. It is stated that he is regarded insane because he is "unruly;" also, because he danced when prisoners were going to dinner, made a noise at night, and disturbed the chapel services on Sunday.* The patient is now in good general health, is coherent in conversation, and quite responsive; says his "head is not right," and that he "knows" he "is crazy."

October 3d, 1876. Patient has slept well since admission; appetite and general health good. Is beginning to show a discontented, fault-finding spirit, not inclined to comply with the rules of the Asylum, and seems anxious to be considered insane.

October 6th, 1876. Since readmission the patient has been carefully examined daily, by both the superintendent and assistant physician, with special reference to his mental condition; and in addition to this the attendants and night-watchman were instructed to observe him carefully, and to report the result of their observations, in full, to the medical officers. (These extra precautions were deemed necessary, in view of the fact that employees of the Asylum, who knew Barr when he was here before, stated that he was "an ugly customer," and a "feigner," and that he was so regarded by the late superintendent; also, because he was reported to have said to a comrade, while at the prison, "I have been in the

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Asylum once, and I propose to go there again, if I have to kill a keeper to accomplish it.") The past history of the patient, as obtained from various sources, together with the entirely negative result of the thorough search for evidences of insanity, that has been made during the last nine days, would seem to justify the opinion that he is not insane, and he is, therefore, in accordance with said opinion, returned to prison this day.

During the four months that elapsed between his return to prison and the time of the murder, Barr spent most of his time, during the day, in what was then known as the "idle shop," from among the occupants of which it was customary to make details, as occasion required, to police the prison grounds, and to do other work about the premises, including the removal of snow, in winter, from the sidewalks outside of, and adjacent to the prison walls.

On the first day of February, 1877, Barr, with a number of other convicts, was engaged, under the supervision of a keeper, in clearing the snow from the sidewalk of the street in front of the prison. Pedestrians were frequently passing to and fro on that side of the street, and when the passer-by happened to be a lady, Barr would try to attract her attention, and then lift his hat, smile at her, and make the gesture of "throwing a kiss." The keeper reprimanded him for this, and commanded him to desist, at the same time threatening to send him in if he did not obey, at which Barr became angry, refused to work, and declared he would not go in until the rest did, and further manifested his contempt for the keeper's authority by conversing with the other convicts, which was against the rule. The keeper again reprimanded Barr for his insolence and disobedience of orders, and ordered him to pass in at the gate, which Barr refused to do, whereupon the keeper wrote a note, which he handed in to the gate-keeper, Barr watching him all the time, and

no doubt surmising that the keeper had sent for an officer to come and take him in. Just at that moment a citizen, passing along, spoke to the keeper, and as the latter turned to reply, Barr dealt him a violent blow upon the head with a shovel, the force of which crushed in his skull, and felled him to the ground. Barr continued his murderous assault until driven off by a fellow-convict, who raised a pickaxe and threatened to kill him if he struck again. He then fled down the street, but was soon apprehended by an officer who happened to be in that vicinity, and was speedily returned to prison, and placed in the "dungeon." The unconscious keeper was carried into the prison hospital, where he soon expired. Barr remained in the prison until indicted for murder by the grand jury, when he was removed to the county jail.

The murder, as just described, created intense excitement in the city of Auburn, and gave rise to a good deal of newspaper comment throughout the State, the general tenor of which was (excepting that in the Auburn papers) that Barr was insane because he had been an inmate of an asylum, and had subsequently committed a homicide.

Immediately upon his removal to the county jail, Barr began to act in a most foolish, absurd manner. He made irrelevant replies to questions, muttered incoherently to himself, about "spirits" and "devils," destroyed his clothing and bedding, and for several weeks he not only disturbed the inmates of the jail, but the entire neighborhood, at night, by his demon-like yells. It was noticeable, however, that he was noisy during the early, and slept during the later portion of the night. Persons living in the vicinity of the jail, having complained of the noise to the jailor, that official tried, by persuasion and other mild means, to suppress

it, but was unsuccessful until, as a *dernier ressort*, he "got out the hose and literally turned it on him." After this Barr was quiet, and beyond an occasional attempt to obtain articles of various kinds, which could be used as weapons, his jail life was comparatively uneventful until the time for his trial approached. Able counsel was assigned to defend him, but Barr, persisting in his ridiculous actions and disconnected conversations during the visits of his counsel, succeeded in impressing him with the idea that his client was insane, and when the case was called for trial, he entered a plea of "not guilty, on the ground of insanity." Subsequently, the defense applied to the Court for the appointment of a commission of medical experts, to examine Barr with reference to his mental condition. The application was granted, the court appointing as such commission, Dr. John P. Gray, Superintendent of the State Lunatic Asylum at Utica; Dr. John B. Chapin, Superintendent of the Willard Asylum; and Dr. Theodore Dimon, an ex-prison physician, of Auburn. The commissioners, after making an exhaustive investigation, submitted their report, of which the following is a copy:

THE PEOPLE

vs.

WILLIAM BARR.

To the Court of Oyer and Terminer of Cayuga County:

We, the undersigned Commissioners, appointed by the order of said Court, on the 9th day of October, 1877, in pursuance of the provision of Chapter 446, of the Laws of 1874, and the acts amendatory thereof, to inquire into the mental sanity of the said William Barr, under indictment for murder in the first degree, and arraigned for trial, and report in writing to said Court "as soon as possible, the fact of the mental sanity of the said William Barr, at the time of the alleged offense in said indictment against him," do hereby certify and report that we have executed the said order.

In accordance with said order we met at Auburn, Cayuga Co., on the 11th day of October, and proceeded to examine witnesses, under oath, which evidence was reduced to writing by John B. Chapin, one of the commissioners; that we also personally examined the said Barr; that subsequently, on the request of the commissioner, the Court appointed a stenographer to take down testimony, and we therefore adjourned to the 23d of October, when the hearing was resumed, and we took testimony on that day and the day following; that H. V. Houland, counsel for said Barr, having addressed a communication to one of the commissioners, which is hereunto annexed, and having named therein the following persons whom "he" intended to call as witnesses for Barr," viz.: Drs. Hamlin, B. K. Hoxie, C. F. Durston, Esq., Capt. George Jenkins, Capt. Wm. H. Boyle, Capt. Geo. Sherlock, Dr. J. D. Button; we called and examined the said persons and other witnesses, and again personally examined the said Barr; that we also issued an order to the clerks of Sing Sing, Clinton and Auburn prisons to produce certified copies of all records concerning the said Barr, as now contained in the record-books of the said prison, all of which orders and answers are hereunto annexed, when we adjourned to November 7th, and again met and took testimony, and on the seventh again examined the said Barr. A copy of all the testimony taken, and all the papers before us are herewith returned and filed with this our report. That having made careful investigation into all matters embraced in said order of the Court, and referred to us, we do certify and report, that from all the facts brought before us, and from our personal examinations of the said William Barr, we are of the opinion that he was sane on the first day of February, 1877, when the alleged homicide was committed, and is sane now.

JOHN P. GRAY,
JOHN B. CHAPIN, } *Committee.*
THEODORE DIMON, }

November 8, 1877.

The trial began shortly after the above report was presented, and Barr's counsel, having no other ground, made insanity the sole defense, notwithstanding the finding of the commission. Four physicians, including the two who had respectively committed him to the Asylum, were called as "experts," to testify to Barr's

insanity. One of these witnesses testified that he regarded the prisoner as a case of "acute mania" when he sent him to the Asylum in 1874. Another said that he was suffering from "paroxysmal mania and melancholia," when committed to the Asylum, by him, in 1876, and admitted that "he might have feigned all this except his physical condition," also, that "he exhibited at one time, in the prison jail, a silly laugh, which I (he) thought was peculiar." The third medical witness divided insanity into two forms, namely, "mania and delusion," and thought that Barr's case came under the latter; while the fourth gave it as his opinion that the form of insanity was "mania *without* delusion," but at a subsequent stage of his testimony, stated that the prisoner's declaration that there were devils and spirits in his cell, was undoubted evidence of delusion. The medical witnesses called on the part of the people, were Dr. Theodore Dimon, ex-prison physician and one of the commissioners, Dr. J. D. Button, present prison physician, Dr. W. Channing, ex-assistent physician to the Asylum, and the writer, all of whom expressed the opinion that Barr was sane then, and, also, at the time of the murder.

During the trial Barr would frequently laugh and "grin" in a silly manner, or mutter to himself, and make grimaces and queer gestures, which, of course, attracted attention, and "convinced" some of the spectators that "he must be insane."

The jury, after deliberating one hour and twenty minutes, returned a verdict of murder in the second degree, (no premeditation having been shown,) and, accordingly, Barr was sentenced, on the 23d day of November, 1877, to State prison for the term of his natural life. After the jury came in, and while the roll was being called, preparatory to receiving their

verdict, Barr watched the proceedings with an anxious countenance, apparently forgetful, in his anxiety as to the result, of his demeanor during the progress of the trial. He soon recovered himself, however, when the decision was announced, evidently realizing that all eyes would be turned upon him to see how he received it. Reaching his old quarters at the State prison, and while donning again the convict garb, the deputy warden asked him why he refused to recognize him in the court room? Barr replied, "well, Cap., you know I wasn't recognizing anybody then." He also, about this time, wrote a long letter to his brother.

Barr was placed in solitary confinement, and extra precautions taken against his escape, yet, notwithstanding these he made two desperate efforts to obtain his liberty by cutting the iron bars of his cell door. In one of these attempts he succeeded in removing an entire section of the door, to accomplish which, he was obliged to saw through four iron bars, each two inches wide by one-half inch thick, and when discovered the only implement found, after a thorough search of his person and cell, was a small shoe knife with an irregularly serrated edge, which he had surreptitiously obtained. In the second attempt he succeeded in making a cut in one of the bars nearly half an inch in depth, by mere attrition with a wire which he had slyly removed from the rim of his soup basin, readjusting the tin so nicely that its removal was not discovered by the guard who served his food. Estimating the time he would have to work between the visits of the guard, the prison officials were of the opinion that these operations upon the door must have occupied him for several weeks. The section removed consisted of two pieces of iron, of the width and thickness described, each about six inches long and bolted together in the middle, forming

a cross; to this he attached a cord, made of bed-ticking, which he wound about his wrist, and when discovered, was standing with his right hand behind him so as to conceal the murderous weapon with which he was prepared to attack the guard.

These acts on the part of Barr not only strengthened the opinion that he was sane, but demonstrated to the prison authorities the necessity of confining him in such a manner as would render his escape utterly impossible. This was done by placing additional iron "night guards" upon the doors of the dungeon in which he was kept. After this he seemed to realize, for the first time, that every chance of escape was cut off, and that he had nothing in the world to look forward to but a life of solitary confinement; and, doubtless, this feeling was strong within him, when, in the quiet of the following Sunday, he terminated his earthly existence by hanging himself from the topmost cross-bar of his cell door. An autopsy was made by the writer, at the request of the coroner, Dr. Shank, in the presence of the latter and seven other physicians of Auburn.* So far as could be determined by the naked eye, the post-mortem examination revealed a healthy state of all the bodily organs, including the brain, with the single exception of a very slight tubercular deposit in the apices of the lungs, a not uncommon sequel of long confinement in a vitiated atmosphere. But in order to determine definitely respecting the correctness, or otherwise, of the conclusions, based upon a gross examination, that the brain presented no evidences of disease, specimens, taken from its several anatomical divisions, were forwarded to Dr. Gray, Superintendent of the State Lunatic Asylum at Utica, who had them exam-

* Drs. Armstrong, Briggs, Bates, Brinkerhoff, Creveling, Theo. Dimon and Luce.

ined microscopically by Theodore Deecke, the pathologist connected with that Institution, who reports that the brain structure was entirely free from disease.

Inasmuch as public attention has been a good deal occupied with the subject of the foregoing sketch, it may be worth while, in view of the diversity of opinion which existed respecting his mental condition, to refer briefly to the circumstances, some of which are not generally known, surrounding the events of which mention has been made, in order to indicate, as clearly as possible, the grounds on which the unavoidable conclusion that Barr was not insane rests. From his history, as given, prior to the killing of his keeper, it is not clear that he manifested any continuous or fixed method in his pretended madness. In fact, beyond his occasional assertions that he was insane, or "not right" in his head, his conduct appears to have been characterized more by vicious acts and propensities, in keeping with his criminal nature, than by any systematic effort to feign insanity. It may seem strange, at first sight, that, being regarded as not insane, he was permitted to remain in the Asylum for two years; but this is explained by the fact of the superintendent's belief, as told by his subordinates, that Barr's propensity for fighting and insubordination in general, would, in all probability, soon lead to his recommittal to the Asylum as the easiest way, in those days, of disposing of a troublesome, "unruly" convict. Then, too, the possibility that his transfer back and forth, from prison to asylum, would give rise to an unpleasant conflict of professional opinion between the medical officers of the two institutions, may have operated to prevent an earlier discharge. But, even if no explanations of the fact were at hand, incontestable proof of the then superintendent's opinion of Barr's mental status is furnished by the act of that

official who returned him to prison as *not* insane, after having had him under observation for two years.

It will be remembered that Barr was first committed to the Asylum as a case of "chronic mania and melancholia" without apparent "lucid intervals," while the second certificate declared him to be suffering from "paroxysmal mania and melancholia." Those having a moderate knowledge of the manifestations of insanity need hardly be reminded that these two forms of disease are not likely to be found associated together, as *chronic* conditions, in the same individual; but even admitting, for the moment, that Barr's mental state was, at the time of his second commitment to the asylum, what the certificate alleges it to have been, at once the question arises, upon what possible hypothesis can we explain the fact that no indications of such a state, or of any form of insanity were discovered when he came under the observation of the writer? Surely no medical mind will believe that a chronic state of "paroxysmal mania and melancholia" which was clearly appreciable to a physician, *without asylum experience*, would subside, during the ten minutes' walk from the prison to the asylum, so as to be quite inappreciable to the Asylum physicians. Such sudden transformations of mental and physical symptoms are not to be found among the phenomena of mental disease. If we go a step further and assume that he came to the asylum during the interval stage of "chronic paroxysmal mania" would it not be right to expect to find some vestiges of the physical conditions resulting from former paroxysms? Experience answers in the affirmative. As regards the diagnosis of melancholia in a case where not the slightest trace of its essential mental characteristic, depression, is observable, no comment is necessary. With ordinary carefulness in examination at the asylum some indications of

these conditions, had they existed, would have come to light; and the fact that none were discovered, after a reasonable period of unusually careful observation, together with his previous history and the report that he had expressed a determination to return to the Asylum, even if he had "to kill a keeper to accomplish it," affords to the writer's mind solid ground for the opinion that, *up to the time of his final discharge from the asylum, William Barr was not insane.*

Let us now proceed to a consideration of Barr's subsequent career, for the purpose of determining whether there were, in its further developments, any reasonable grounds for regarding him as insane. It may be said that, admitting him to have been sane when he left the asylum, insanity might still have developed during the four months that elapsed between that event and the occurrence of the murder. Now, whether there was anything in his condition or conduct during that period, which attracted the attention of the prison physician to his mental state, the writer is not aware; but it is reasonable to suppose that his custodians did not consider him "a dangerous lunatic," as otherwise they would not have placed him where he was at the time he committed the murder.* Up to the time of the killing, the fact that Barr was not insane could easily be determined by the absence of indications of insanity, without reference to his feeble efforts at feigning; but the marked change in his conduct after that event, and coincident with his removal to the county jail, at which time his efforts to simulate really began in earnest, when considered in connection with certain circumstances discovered by the jail officials, and his conduct

* The writer saw Barr engaged, with others, in cleaning snow from the sidewalks, and exchanged recognitions with him several times during the winter of 1876-7.

when returned to prison after the trial was over, furnishes the most striking evidence of a very bungling attempt at shamming. He suddenly evinces a complete loss of memory respecting himself and the most recent events in which he figured so prominently; looks down, or away, when approached, and when interrogated returns irrelevant and incoherent replies; complains of "devils" and "spirits;" destroys his clothing and bedding, and is very boisterous—shouting, singing and whistling during the *early* portion of the night. The noise, however, permanently subsides after a single application of the jailor's rigorous, hydropathic treatment. It is worthy of remark, in this connection, that while such treatment, in the case of a genuine maniacal lunatic, would most likely have "added fuel to the flames," it completely extinguished Barr's noisy propensity. After this he substitutes the role of extreme stupidity and silliness for that of boisterous mania. A striking similarity to the recorded conversations of other feigners is shown in the following extract from a verbatim report of a conversation between Barr and the commission, during one of its sessions:

- Q. How old are you? A. I don't know, sir.
Q. Were you born in this country? A. I don't know.
Q. What is your name? A. Barr.
Q. What is your first name? A. William.
Q. Your brother's name? A. I ain't got no brother.
Q. What was your mother's name? A. I don't know, sir.
Q. You say you don't know where you were born? A. No, sir.
Q. Do you mean to say that? A. No, sir.
Q. Where were you brought up? A. The devil is all the time talking to me.
Q. Do you know Captain A (a keeper at the prison)? A. No.
Q. Do you know Captain B? A. I don't know any of them at all.

Q. Do you know Captain C? *A.* No.

Q. Do you know Captain D? *A.* Where.

Q. Do you know Captain E? *A.* No, sir.

Q. Do you know your brother's name now? *A.* You know the devil is all the time talking to me about. Could hear him well enough, and I don't want to hear. That is the matter.

Q. You say the devils are all the time talking to you? *A.* Yes, sir; you know.

Q. What do they say? *A.* They won't let me rest.

Q. Tell this gentleman what they say, and he will write it down? *A.* I don't want it written down.

Q. Can you read or write? *A.* No, sir.

Q. When did you forget to read and write? *A.* You will all write too.

On another occasion he was again asked where he was born, and replied, "I guess so; what do you want to talk to me for?" The question was repeated, and he said, "What are you talking to me for? There are seven hundred thousand devils flying around all the time; you know what they say."

Dr. A. E. Macdonald, in a recent lecture, says: "The man who feigns insanity is most apt to think it incumbent upon him to show an utter loss of memory and reason. So if a man pretends forgetfulness of his own name, the names of his family and friends, recent events and such simple things, you may well suspect that he is an imposter. It is always suspicious when the man avoids answering questions, or pleads inability to answer, on the ground that he can not remember."

Barr continued to conduct himself in the manner stated above, whenever he appeared before the commission, and also in the court-room, during his trial; but at the jail, after the jailor had made his rounds for the night, and passed out, he would throw off the mask and talk freely with a convict by the name of Thorp, whom Barr had known in prison, and who was then under sentence of death for the murder, in prison, of a fellow convict. Thorp was allowed cigars, newspapers

and other little extras, which he usually shared with Barr, who was in an adjacent cell, passing them to him by means of a string, which the latter manipulated. By this means Barr was enabled to learn the progress of his case, as reported in the daily papers, which he obtained from Thorp, and read late at night. He also wrote and sent coherent messages to Thorp, one of which fell into the hands of the commission, and read as follows:

friend Thorp, i have got a Hard time of it they have tried to hang me but they are not smart, i am Oblige for Ciger.

BARR.

At a late hour on the night after the session of the commission, during which the conversation, shown above, occurred, a deputy sheriff, secreted in the corridor on which Barr was locked, overheard a conversation between the latter and Thorp. It seems that Barr had been reading an evening paper which contained a comment on his case, and, attracting Thorp's attention, said to him, "Them —— of —— down to the court house are trying to hang me, but I think I'm too smart for them." Then after further comment on his case, said to Thorp, whom he knew was to hang in a few days, "You'll soon know whether I'm to join your band or not." Thorp asked Barr who the man was that came in to see him the day before. Barr replied, "That's the man that's going to get me out of this." The man referred to was his counsel. Barr asked Thorp to send him "a stiff," which means, in convict parlance, "a letter." Hearing a noise outside, Barr said, "cheese it Thorp the boss is coming, he'll hear us talking." "Cheese it" is convict slang for "shut up" or "stop it."

Taking Barr's conversation and conduct before the commission, and placing it beside of that which he ex-

hibited to Thorp, no later than the following evening, and we have a mass of ludicrous inconsistencies that are at variance with every known form of insanity; and yet how accurately it answers to the descriptions given of feigners in the various works on mental disease. Here we find him, in the morning, manifesting an apparent loss of mental capacity, to a degree that would not be expected in any form of insanity, short of complete dementia. While in the evening of the same day, when he supposes he is heard only by his comrade and confidential friend, he drops the disguise, and displays a degree of shrewdness and comprehension, quite in keeping with his actual mental condition and capacity.

If we take the prominent features of a given case of real lunacy, and group them together, the result is a consistent whole, which can be classified in some one of the several recognized forms, and to imitate which, with any degree of success, even for a short time, would require the dramatic powers of an accomplished actor, and then the physical symptoms would still be wanting. On the other hand, the feigner, as a rule, to which Barr's case is not exceptional, having no conception of the order or sequence of the symptoms, or of the forms of the disease he is trying to simulate, presents but a medley of inconsistencies, which almost invariably leads to his detection.* He merely supposes that a lunatic is one who has, to use a common phrase, "lost his mind," hence he strives to show that his own mind is gone, by conducting himself in the most absurd manner. He pretends not to know the simplest facts about himself, such as his age, nativity or civil state;

* It will be remembered that Barr had had opportunities for observing the conduct of insane persons, during the two years he was in the Asylum, but lacking a knowledge of the conditions underlying such conduct, his attempts to imitate insanity, could only result in failure.

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fails to recognize his nearest and familiar acquaintances; says he can not count or tell the day of the week, and frequently reverts to the subject of his pretended delusions or hallucinations; he avails himself of every opportunity to attract attention, and his symptoms seldom fail to assume an unusual degree of activity whenever he is conscious of being observed. Unlike the genuine lunatic, he tells you that he is insane, or "out of his head," and is not offended at being "accused of lunacy."

"The real lunatic when you accost him will summon his wits together, brighten up, and for the time seem less insane than he really is. The impostor, on the contrary, dismisses his wits altogether, and is more absolutely and abjectly insane when you speak to him than at any other time."*

At no time during the examinations of Barr did his physical system present any of the symptoms that would almost certainly have been present had his mental manifestations been those of real lunacy.

If Barr was suffering from any form of insanity at the time he was before the commissioners, it must have been dementia; but his communications with Thorp about the same time, and the reason, (which was virtually a confession,) which he gave for not recognizing the deputy warden in the court-room, together with his letter to his brother, his subsequent attempts to escape from prison, and the circumstances of his death, are entirely inconsistent with the idea of dementia.† Another element not heretofore mentioned in this case,

* Feigned Insanity. A lecture delivered before the students of the Medical Department of the University of the city of New York, by A. E. Macdonald, M. D.

† During the period of Barr's last imprisonment, the writer saw and conversed with him several times. On these occasions he showed no signs of insanity.

and one which according to all authorities, furnishes a strong presumption of feigning, is the presence of a very powerful motive; and what could offer a greater inducement to the hardened criminal than a desire to escape from punishment for crime?

The fact that Barr ended his life by suicide, may be regarded by some as evidence that he was insane, while the truth is, it furnishes strong proof of the contrary, supplying, as it does, the last link, but one, of the chain of evidence which demonstrates conclusively that he was "clothed in his right mind." A moment's consideration of the circumstances surrounding the fatal event can hardly fail to satisfy even the most skeptical of reasonable men that it was the deliberate act of a sane man. He had experienced the humiliation of detection and exposure in his attempts to feign insanity, had been in solitary confinement for nearly a year, had failed in all of his efforts to escape, knew that it was useless to hope for a commutation of sentence and realized, as he intimated, that the additional security recently given to the dungeon, in which he was confined, rendered escape therefrom impossible. These circumstances furnish, to a man like Barr, a rational and powerful motive for the act which required far less courage to execute than it would to have endured, for an indefinite period, the hopeless situation from which there was no other means of escape. The fact too, that he selected a time (Sunday) when the infrequent visits of the guard reduced the chances of discovery in the accomplishment of the act to the minimum, is significant as showing that he possessed an appreciation of his surroundings.

Doubtless there are still a few individuals in every community who, in spite of the most convincing evidence to the contrary, refuse to believe that suicide is ever the act of a sane mind. Yet history, both ancient

and modern, is replete with well authenticated instances of deliberate self-murder by individuals of unquestionable sanity, for the purpose of escaping some impending evil or misfortune, or the consequences of crime. What rational, intelligent being but can imagine an environment to the endurance of which death would be far preferable! "That sane people commit suicide," says Blandford, "is a fact that must be apparent to every one who exercises common sense in looking upon the subject." Dr. Ray, in speaking of suicide, says: "We know well enough that life is not so dear that it will not be readily sacrificed when all that makes it worth retaining is taken away," and Bucknill and Tuke declare that it can not be disputed that suicide may be committed "in a perfectly healthy state of mind." Instances of condemned criminals cheating the gallows through the avenue of suicide are not rare, and in some cases the means to accomplish it are secretly supplied by friends. What evidence of insanity can be found in the act of self-destruction under such circumstances? "That many rush into suicide," says Winslow, "in order to escape the just and legal punishment of their crimes can not be a matter of doubt." These conclusions respecting suicide are also fully sustained by Dr. Gray,* in his able review of the subject which appeared in the July number of this JOURNAL.

* Lecture delivered at Bellevue Medical College, March, 1878.

ON THE EPITHELIUM OF THE CENTRAL CANAL OF THE SPINAL CORD AND OF THE VENTRICLES OF THE BRAIN.

BY THEODORE DEECKE.

The epithelial covering which lines the central canal of the spinal cord and the ventricles of the brain, has, at different periods, been an object of discussion. Two theories have been advanced as to its nature. They may aptly be denominated the connective tissue and the nerve tissue theories, and are the expression of views, of general and special interest, involving the position of the epithelia among the tissues, and their physiological significance.

Purkinje,* 1836, discovered that the lining consisted of cylindrical epithelium cells, which were provided with cilia, a fact which, at first disputed by other observers, in the course of time became universally acknowledged. About eight years later, Hannover† examined the covering of the ventricles in the brain of frogs, and found that filiform processes were attached to its cells, which projected into the subjacent tissue. He took these processes for nerve fibers, and looked upon the terminating epithelium cells, accordingly, as nerve cells. It was from this time that the tissue which supports these cells was subjected to a closer examination. Virchow‡ described it as a streaky, connective tissue-like layer. Some years later§ he saw in it represented the simplest

* Müller, Archiv, 1836, pag. 291.

† Recherches microscopiques sur le système nerveux, Copenhagen, 1844, pag. 20.

‡ Zeitschrift für Psychiatrie, 1846, Heft 2.

§ Virchow, Archiv VI, pag. 136; Gesammelte Abhandlungen, Frankfurt, 1856, pag. 890.

form of that connective substance, peculiar to the nervous centers, the neuroglia, of which their framework was found to consist. And, with this, he gave the first impulse to that voluminous literature on the connective tissue of the central organs, which finally led to the acknowledgment of different forms of this tissue in the different provinces of the centers, and to a more minute division between its elements and those of a true nervous character. The part which is here of interest to us, the central ependymal thread (Virchow), the grey central nucleus (Kölliker), the gelatinous central substance (Stilling), surrounds the central canal of the spinal cord, and the ventricles of the brain as a ring merging imperceptibly at its periphery, into the grey matter. It presents itself as a soft substance, of homogeneous, streaky, or even at certain points finely fibrous appearance; also numerous cells enter into its composition, which have been partly described as the so-called Deiter's cells of the neuroglia, partly as radiated or multipolar cells, and fusiform cells, the nature of which has remained, at least, doubtful; the same must be said in regard to the fibers traversing the tissue, with the exception of true connective tissue ramifications of the pia mater, which project into it. The descriptions of the cells, as given by different observers, do not harmonize, which is undoubtedly, in some part, the result of the different methods of preparing the tissue for examination; they are, however, by far not uniformly distributed through the substance in question, and the one or the other kind may be found here or there, in a larger number. Stilling* and Kölliker† disagree in the size of the cells. Frommann‡

* Neuere Untersuchungen über das Rückenmark Frkf. 1857, Cassel 1859, pag. 32.

† Mikroskopische Anatomie I, pag. 411 ff.

‡ Untersuchungen über norm. und path. Anatomie des Rückenmarkes, 1864, I, pag. 13 ff, and 77 ff.

and Stilling in regard to the nucleus of the cells. Lockhart Clarke* saw small round or angular, granulated or nucleated corpuscles, from which filaments proceeded which were in connection with fibers of the gelatinous substance, while Lenhoussek† observed only cell like, yet not nucleated bodies. Of fibers which in a transverse direction cross the gelatinous substance, Stilling distinguishes two kinds, of great fineness; the one in circular lines surrounding the central canal, the others in a radial course traversing the sub-epithelial layer. They are both claimed to be in connection, on the one hand, with the processes of the epithelium cells of the central canal, and on the other with the fibers of the septa, and with processes of the cells of the gelatinous substance. The radial fibers are described as direct continuations of the epithelium cylinders, which run out into the connective tissue fibers of the anterior and posterior median septa. Fibers of the same kind have been observed by Clarke and Frommann; also Goll‡ spoke of fibers of the ependyma, which interweave, forming a network of small meshes. Goll took these fibers for nerve fibers, while Stilling declared himself in favor of the nervous nature of the cells, even of the cylindrical epithelium cells of the central canal and the ventricles, and in opposition to the views of Bidder,§ regarding the connective substance of the grey matter, who asserts that the filiform processes of the epithelia, connect either with connective tissue fibers, or connective tissue corpuscles, or that they run out into the amorphous layer of the central grey nucleus of

* Philosophical Transactions, 1859, I, page 454 ff.

† Neuere Untersuchungen über den Bau des centralen Nervensystemes, 1855, pag 19.

‡ Denkschriften der med. chir. Gesellschaft, Zürich, 1860.

§ Bidder und Kupfer Untersuchungen über das Rückenmark, Leipzig, 1857.

the cord. In an interesting paper on the aquæductus Sylvii, Gerlach* took about the same position as Bidder, yet was undoubtedly influenced by Billroth's† new theory on the structure of the cylindrical epithelia, and their relation to the connective tissue in general, which was the source of a discussion, that for some time occupied the interest of the histologists. Gerlach, however, was fully aware of the importance of the question, whether the one or the other theory should be confirmed. In the one case, if the ciliated epithelia of the axis canal of the cord and the ventricles of the brain were to be considered as nerve elements, we would have to acknowledge the existence of a moving phenomenon inside of the central nervous system, which would be directly accessible to sensory perception; in the other case some light would be thrown upon the position of a certain class of epithelial formations in the general economy of the animal organism, and upon their development and reproduction. When Gerlach preferred to believe in the connection of the epithelia with connective tissue elements, he was principally led by the fact that in all his numerous preparations he never met with a fiber of an indisputable nervous character to which an epithelium cell was attached, and by the circumstance that Billroth's theory, soon after its publication, found an advocate in as accurate an observer as Heidenhain.‡

The leading points of the question were the following: Billroth proceeded from the discovery of an intimate connection between the cylindrical epithelia of the tongue and the fibrous texture of the papillæ. As the latter consisted, unquestionably, of connective tissue

* *Mikroskopische Studien*, Erlangen, 1858, pag. 32.

† Th. Billroth, Ueber die Epithelialzellen der Froschzunge und ihr Verhältniss zum Bindegewebe; *Deutsche Klinik*, 1857, No. 21, und *Müller Archiv*, 1858, pag. 174.

‡ *Die Absorptionwege des Fettes*. Moleschott, *Untersuchungen IV*, 1858.

fibrillæ, he thought it justifiable to consider the epithelial cells merely as appendices to those connective tissue formations, from the elements of which they had developed and had been constantly reproduced. He abandoned the theory of the isolated position of the epithelia among the tissues, and extended his views over the whole class of the pedunculated and ciliated cylindrical epithelia. In the relation, then, of these two groups of tissues to each other, he believed that he had discovered the clew to an understanding of certain phenomena connected with the processes of the resorption of substances in all channels and spaces of the animal organism which were lined with these kinds of epithelial formations. A closer investigation into their minute structure seemed to support these views. In chronic acid preparations these cylindrical cells acquired the appearance of being provided with a pit at the upper surface, around which, or in which, the cilia were arranged in a circular line at the border of a kind of funnel-shaped orifice. Other observers, from the longitudinally striated appearance of the whole cell, or of its upper part, which then like a flat cover seemed to bound the cell, explained these as pores or minute ducts through the body of the cells. It was thus but a natural consequence to presume that the peduncle at the foot of the cell—the direct prolongation of its walls—in reality was a tube which served as a canal for conducting substances, taken up by the cells, into the deeper layers of the tissue. For the digestive tract Heidenhain, indeed, was convinced that he could prove the existence of such an arrangement by direct experiments. Consecutive upon injections of oil into the stomach of frogs, he saw the epithelium cells and their processes filled with finely-divided fatty matter, and he founded upon this his theory of the absorption of fatty

substances in the processes of digestion. Furthermore, however, he claimed the discovery of the existence of a system of ducts in the sub-epithelial connective tissue layers, into which the tubiform prolongations of the epithelia emptied, and which communicated with the lymphatics of the digestive tract.

In spite of the objections of Kölliker,* Heidenhain found followers, and Friedreich† applied the theory to the epithelial covering of the ventricles of the brain. He puts much weight upon the striated appearance of the flattened or slight convex cover of the cells, and of that of the body of the cell itself, and he explains the striæ as a system of very minute capillary tubes, which traverse, in longitudinal lines, the body of the cell, and which terminate in the cilia. He also thinks it justifiable to bring these structural arrangements in connection with the processes of resorption in general, and he presumes the existence of a direct communication between the ventricles of the brain, and the central canal of the spinal cord on the one side, and the general lymphatic system on the other. This is accomplished by a system of canals, commencing from the cilia of the epithelium cells, and terminating, by their filiform prolongations, in connective tissue corpuscles, which represent the first elements in the construction of lymphatic ducts.

In regard, also, to other epithelial formations, the connective tissue theory found its advocates, and here Stilling, in another part of his work before mentioned, brought it to a culminating point. According to his views the whole fibrous body of the dura mater, the arachnoidea, the pia mater, were formed by, or composed of the manifold divided and multiplied filiform processes of the numerous epithelia which cover their

* A. Kölliker, *Gewebelehre* 3te Aufl. pag 424 ff.

† Virchow, *Archiv* XV, pag. 535.

surface. All the connective tissue fibers in the neighborhood of the spinal cord, are claimed by him to be but prolongations of epithelium cells. The epithelia of the cornea, of the serous membranes, the mucous membranes, the cutis, etc., he claims to be provided with processes which form fibers, so that all connective tissue between the muscles of the trunk, and the extremities probably, were in connection on the one side with the epithelium of the cutis, and on the other with that of the thoracic and the abdominal cavities.

Nothing of this, however, has been confirmed. The views of Billroth and Heidenhain were criticised by Hoyer,* who, warned against premature theories. He denied all connections, at least of the epithelia above the termination of the nerves, with connective tissue fibers or corpuscles. L. Ranvier† rejects the conclusions of Heidenhain entirely. In regard to the development and reproduction of the epithelia, we must refer to the investigations of Heiberg,‡ who studied the mode of regeneration of the epithelium of the cornea, and the epithelia in general. He arrived at the following conclusions: A participation of wandering (connective tissue) corpuscles in the regeneration of epithelia does not take place; an amorphous blastema as a basis substance for the regeneration of epithelia has not been observed; the regeneration of epithelial cells proceeds from epithelial cells around the border of the defect. These statements were, in the main, con-

* Mikroskopische Untersuchungen über die Forshzunge. Reichert und Du Bois-Reymond, Archiv 1859, pag. 501.

† Nouveau Dictionnaire de Médecin, Art. Epithelium. Paris, 1870.

‡ Ueber die Neubildung des Hornhaut Epithels und des Epithels im Allgemeinen, Stricker. Studien, Wien, 1870.

firmed by G. Lott,* by Rollett,† and others, and are undoubtedly not in favor of an existing intimate connection between epithelial and connective tissue formations.

Other difficulties with which the theory meets, arise when we consult the history of the development of the tissues of the animal organism. The rudimentary embryonic body, according to Remak,‡ consists of three leaves or germinal plates, the superior corneous, the intermediate or middle germinal, and the inferior or intestinal glandular leaf or plate. From the corneous plate originates first of all the epithelial covering of the body. The axial portion enters into the construction of the nervous centers and the internal portions of the organs of sense. The inferior or intestinal glandular plate supplies the epithelia of the digestive apparatus, of the glands including lung, liver, etc. These epithelial formations principally appear in the form of cylinder cells, either naked or ciliated. The middle germinal plate, finally, in which the whole group of connective tissue substances originates, supplies the class of so-called false epithelia, or the endothelia of His.

We see, therefore, that the two groups of tissue have their separate mode of development from the beginning. It is true that against the validity of this argument, the fact has been offered, that in the last instance, all form elements of the animal organism originate from one source, but this objection can hardly be sustained. Both groups belong to well defined series of formations which, although proceeding from a common point, develop in entirely different directions, and as nature, in

* *Centralblatt für medicinische Wissenschaften*, 1870, No. 37, und, *Untersuchungen aus dem phys. Institute in Graz*, 1873.

† *Stricker, Gewebelehre Art. Hornhaut.*

‡ *Embryology.*

all differentiations, invariably marks the course which she has taken, we can not presume that she has wiped out the traces, in one direction, in this case.

Excellent means for the purpose of proving the relation of organs and of tissues to each other, are offered in the study of comparative anatomy and histology. In lower classes of animals where the whole plan of organization is more simple, we can almost always expect to find the relation of parts to each other less complicated and more distinct. This refers, in a higher degree, to the tissues which have entered into the construction of the body, than to the organs, of which frequently one or more may be discovered, the true nature of which has remained a secret. The analogy and the homology of the tissues, however, with those of higher developed animals will only rarely become an object of discussion. In regard to the epithelial and the connective tissue formations, and their relation to each other, the study of the organization of the Mollusca offers great advantages. Both systems are highly developed. The different forms of the connective tissue formations do not lack in variety, compared with those of the vertebrata. Here also it presents itself as a continuous system, the cells of which, according to the locality and physiological destination enter into the most various modifications. Especially does this relate to the formative activity of the protoplasm, and the nature and peculiarity of the intercellular substances. The same must be said of the epithelial structures, which in their histological types entirely coincide with those of the vertebrata; the external covering, the epithelial covering of the digestive tract, the epithelia of the glands, the neuro-epithelia. The epithelia of but one layer display here the same fibrous or filiform prolongations into the sub-epithelial connective tissue stratum, as in the verte-

brata, and the ciliated epithelia can not be distinguished from those of the latter. The three animal functions—the resorption, the secretion, the perception, are intimately connected with the life-action of these cells, even where the execution of these functions lies only with a few, for this purpose, differentiated cells. Regarding their relation to the connective tissue, in general, there can not be any doubt. The maceration in a solution of oxalic acid and iodized serum, or bichromate of potash, of one per cent, will facilitate the examination. The epithelia are mostly separated, with ease, from the subjacent connective tissue layer, even where the cell, with manifold divided processes, ramifies between its strata; a connection with connective tissue corpuscles or fibers does not exist.

The structure of the ciliated epithelia may sometimes be observed with great clearness. The head part of the cell is closed by a kind of a cover, or a border of thickened protoplasm, which is perforated like a sieve, and through the foramina of which the cilia project into the body of the cell. The most interesting of all are the neuro-epithelia, which are marked by their connection with or their relation to nerve fibers, and we meet here with the same differences in arrangement and the same modifications in the structure of the form elements as in animals with highly-developed sensory apparatuses. Everywhere, however, are the epithelial formations, characterized by something aboriginal in their structure, and through the whole organism they maintain a structural continuity in such a manner that even the glandular epithelia can but be considered as a direct continuation and inflexion of the surface epithelium. In the higher differentiated animals, with a more independent development of organs, this continuity, of course, is difficult to demonstrate, and although they

originate in the same layer of the blastoderm, it must be admitted that there exists a difference from the very first in the direction of their growth.

It was therefore quite natural to make a distinction between epithelia which grow outward and those which grow inward, the former investing the entire free surface of the organism, the skin and the mucous membranes, the latter occupying cavities formed by the parenchyma of the body. This distinction became the more interesting and important as it, at the same time, indicates a difference in the functional activity of the two classes. The first class comprises the epithelial formation which act as a mediator for the processes of absorption and sensation, or, if we look upon the latter from a mechanical point of view, of absorption alone in its two forms, as the absorption of matter and the absorption of motions. The second class occupy the same position in the processes of secretion.

From all that we know, at the present time, of the peripheral terminations of the sensory nerves, there can not be any doubt of either their direct connection or close relation to epithelial formations. We are only ignorant of the terminations in the mucous membrane of some parts of the alimentary canal. In the manner of terminating, however, aside from the elementary structure, differences will be observed, which should not be overlooked. The nerves of the sense of touch, the optic and the auditory nerves enter with their fibrillæ into epithelial formations; the gustatory and the olfactory nerves terminate *between* epithelium cells. The former, by this arrangement, do therefore not come into direct contact with the motions transmitted to them from the external world. The latter terminate free on the surface of the organs, and are thus exposed to immediate chemical action upon them. The epithelium cells, sur-

rounding the same, predominate in number and superficial expansion, and probably are absorbing cells, and may serve at the same time for the purpose of modifying the action. In the glands there exists an intimate connection between nerve fibers and the secreting cells.

It will be seen from the foregoing that the independent position of the epithelia among the tissues on the one hand, their important functions and close relation to nerve tissue on the other, demand a many-sided consideration. Even the external epidermic cover of the body can not only be regarded as a protecting layer of blood-and-nerveless tissue. It must stand in some relation at least to those sensory nerves which produce the feeling of warmth and cold, and it would appear that the heat must be transmitted through this cellular layer, to give rise to this sensation ; for just as touching a naked nerve, or the trunk of a nerve, produces pain only, so heating or cooling an exposed nerve, or the trunk of a nerve, creates not a sensation of heat or cold, but simply of pain.

I proceed now to a special consideration of the epithelia lining the axis canal of the cord and the ventricles of the brain, which will be the subject of another article.

THE STRUCTURE OF THE VESSELS OF THE NERVOUS CENTERS IN HEALTH, AND THEIR CHANGES IN DISEASE.

BY THEODORE DEECKE.

II.

In a former article in this JOURNAL,* I gave an account of the normal structure of the vessels of the nervous centers. I now proceed to a discussion of the circulatory movements in the cranial cavity. Since the untenability of the old Monroe doctrine, that the amount of blood circulating in the cranial cavity, could not vary so long as the unelastic walls of the skull were not injured, has been demonstrated, experimentally, by Burrow, Donders, Kussmaul, Leyden, Ackermann and Jolly, we look upon the changes in the relative amount of blood, as well as in its aggregate quantity in the brain, just as in any other organ of the body. Notwithstanding this, however, we find arrangements in the central organs for the purpose of regulating the circulation, and of compensating the same, to a certain degree, when the variations exceed the normal standard, which are peculiar to the organ. There is, in the first instance, the cerebro-spinal fluid, discovered by Cotugno, 1764, who saw the fluid filling out the whole sheath of the spinal cord, from the foramen magnum downwards. He placed its site in the arachnoid sac, and he suggested the existence of a communication of this fluid with the contents of the cavities in the brain, through the fourth ventricle, and the aqueductus Sylvii. In 1825 Magendie re-discovered

* Vol. XXXIV, page 18.

the fluid, the existence of which was almost entirely forgotten. He was already fully aware of its physiological significance. According to him and to later investigators, the cerebro-spinal fluid is located between the dura and the pia mater in the sub-arachnoid space. Its quantity amounts to from two to three ounces, and it represents a clear fluid, marked by the small amount of albumen and saline matter which it contains, in comparison with other serous fluids. Magendie ascribed to it the important function of producing a uniform and continuous pressure upon the central organ; a view that in general has been sustained. Leyden* found the pressure equal to from ten to eleven centimeters of water; the pulsatory elevations of the column of water were about 0.4 ctm, the respiratory two to three ctm. These figures show that the pressure is indeed a positive one. It can not, therefore, be surprising that the removal of this fluid was marked by more or less severe symptoms. Cl. Bernard† found that a slow evacuation produces only slight disturbances, as long as the issuing fluid is replaced by air. By the use of an aspirator, however, and by excluding the air tremor developed, which was followed by convulsions and paralytic symptoms. The autopsy revealed a dilated axis canal, small apoplectic foci, and a swelling of the whole substance of the cord. Bernard concludes from this that the fluid serves as a regulator for the circulation in the spinal cord, and that it counterbalances the pressure in the vascular system. With the evacuation of the fluid by the aspirator, under the exclusion of air, the positive pressure was converted into a negative one, which fully explains the pathological alterations referred to. Other

* Ueber Hirndruck und Hirnbewegungen, Virchow, Archiv XXXVII, pag. 519.

† Leçons I, pag. 475.

points of interest are the pulsatory and respiratory movements of the cerebro-spinal fluid. Magendie speaks of these in the following words:

"The sinuses of the cranial cavity, and those of the spinal canal, differ essentially from each other in regard to the physical conditions of their walls. While those of the cranial cavity, of certain dimensions, are not subjected to a variation in the lumen, those of the spinal cord do not resist an alteration of their volume. Tension and rigidity is the character of the former ones, elasticity that of the latter. In the moment of expiration the sinuses of the spinal cord swell and produce a pressure upon the dura mater in the direction towards the cord. We know that the space between the spinal cord and the dura mater is occupied by a liquid; the pressure upon the dura, therefore, is a pressure upon this liquid. What will be the consequence? The liquid will give away in the direction where the resistance is the smallest, it will, since there is no obstruction whatever, enter the cranial cavity. The sinuses of the brain are not dilated, because their walls do fully counter-balance the pressure from the venous blood. The cerebral fluid is exposed to a lower pressure than the spinal, the surplus of the latter will force the fluid into the cranial cavity."

These ingenious views of Magendie are in general adopted by physiologists. Unexplained, however, remains the origin of the fluid, and its closer relation to the vascular system of the nervous centers. Against the theory of a simple exudation, caused by the pressure of the blood, is opposed its composition, which so widely differs from that of other hydropic liquids, and, by the same reason, a direct communication with lymphatic vessels must be denied. Besides, neither the one or the other theory would account for the actual or positive pressure, which the fluid exerts. There remains, therefore, only one suggestion, that is, to regard the cerebro-spinal fluid as a product of secretion of a serous membrane, of the arachnoidea itself, and perhaps of the serous membrane which lines the axis canal of the spinal cord and the ventricles of the brain.

Regarding the actual relation of the cerebro-spinal fluid to the movement of the blood in the vessels which penetrate the central organs, it must be kept in mind, that the substance of the brain and the cord are incompressible. The aggregate quantity of blood, therefore, which at a certain time is in circulation, and the relative amount of arterial and venous blood can only be regulated by arrangements in the structure of the vessels themselves. It is generally accepted that the so-called lymphatic sheath, or the perivascular lymph-spaces, by which the cerebral vessels are claimed to be surrounded, serve as regulators. When the cerebral vessels become distended, a corresponding quantity of the contents of these spaces is displaced, and, conversely, the diminution or the abstraction of blood from the vessels is concomitant with a filling up of their lymphatic envelops. Although there is not yet anything definitely known of the communications of these lymphatic ducts with the sub-arachnoid spaces, the ventricles, etc., and the lymph-glands of the head and the neck, some evidence has been given that such connections do exist.

Gaethgens found, that through an injection of defibrinated blood, under high pressure, into the carotid, the lymph could be made to flow rapidly out of the lymph-vessels of the neck.

Against this theory of general connections, there has only one fact been brought forward, that is, as has been mentioned above, the remarkable difference in the chemical composition of the cerebro-spinal fluid, and of the liquid contained in the lymphatic ducts. Besides, however, it should not be forgotten, that in the former, no organized lymphatic elements have been observed. This awakens the suspicion that the arrangements are not quite as simple as accepted.

In the first part of this paper* I have called at-

* *Loc. cit.* page 23.

tention to some differences in the structure of the so-called tunica adventitia of the arteries and the veins of the nervous centers, which have not yet been taken into consideration. It is only the tunica of the veins which exhibits, in its endothelial structure, the character of a true lymphatic duct, while that of the arteries is built up of other material, of broad, fibrous connective tissue elements, spindle-shaped cells, with long processes, and large, slightly oval nuclei in the outer, and smaller round nuclei in the inner layers of the membrane. This latter, also, does not contain, in health, any free cell-formations of a lymphatic nature. More recent investigations, made on transverse sections through the whole brain, with its membranes, have confirmed these statements. They show that indeed, only the spaces surrounding the veins, are direct continuations of the lymphatic ducts of the pia mater, while the enveloping membrane of the arteries does not stand in communication with the same. This difference is very striking in large sections, examined even with low powers, which permits bringing quite a number of vessels, entering the grey cortex in the field of vision. The funnel shaped mantle of the veins will be found almost always extended, sometimes densely packed with lymph corpuscles, while that of the mostly contracted arteries, either loosely envelops the vessel, or in a collapsed condition, firmly adheres to the muscular coat.

Proceeding now from these anatomical facts to their physiological significance it would appear not unreasonable to modify the views, hitherto advanced, in regard to the roll which these adventitious membranes and their contents play in the circulatory arrangements of the central organs. The condition of the tunica adventitia of the arteries, and its relation to the proper walls of the vessels, demand the assumption that during life

the space formed by it between the elastic walls of the vessels and the organ itself, must be filled out by a liquid body, which counterbalances the pressure of the blood inside the vessels or gives away to it. As now, according to the anatomical relations, these spaces do not communicate with the lymphatic ducts, it seems not to be out of the way to presume the existence of a connection with the cerebro-spinal fluid, and this seems to be the more acceptable, as only by this arrangement the pulsatory movements of this fluid can be explained. We have, therefore, two regulators of the circulation in the central organs, to a certain degree independent of each other, the one belonging to the arterial, the other to the venous system, the importance of which will be fully appreciated, when we consider that by this arrangement the whole capillary system, from all deviation from the normal state, which may occur in the one or in the other direction, will be affected only in the second or the third degree. The principle, condensed in a few words, will be the following: an increase of arterial blood will be attended by a displacement of the cerebro-spinal fluid and, in certain limits, even an elevation of the intercranial pressure may be produced without involving any changes in the normal venous afflux. The venous stasis will be concomitant with a displacement of the contents of the lymphatic spaces, yet without a retardation of the arterial afflux.

The application of this principle to pathological condition will be the object of discussion in a later article. It remains here, for the sake of completeness, to refer to some further arrangements which have been called up for the purpose of explaining other phenomena connected with the regulation of the intercranial circulation, the influence of which undoubtedly must be acknowledged. According to Maingien and Guyon the

thyroid gland is claimed to furnish means for the regulation of the cerebral circulation. When, in consequence of excessive muscular exertion, the veins of the neck become compressed and danger arises of a venous congestion in the brain, the gland, increased in size by this occurrence, is said to press against the carotids, and to diminish, consequently, the flow of blood through them, and to remove in this way the cause of a further distention of the intercranial vessels.

Schröder v. d. Kolk,* from the result of injections, believes that in the pia mater a direct communication exists between the arteries and the veins by anastomoses, so that the passage of the whole amount of blood through the capillaries of the brain substance is not rendered absolutely necessary. This has not yet been confirmed, but Heubner† found that the arteries of the pia mater form a network of anastomoses in such a manner that there exists a free communication between all parts of the membrane, an arrangement by which a compensation in cases of local deviations from the normal state must be facilitated. And Heubner discovered furthermore that the arteries form a second network before they send off branches into the cortical substance of the brain. These anatomical conditions, of course, would add greatly to the protecting arrangement with which the central organs are supplied.

(TO BE CONTINUED).

* *Geisteskrankheiten*, pag. 52, 91.

† *Die Laetischen Erkrankungen der Hirnarterien*, Leipzig, 1874.

AN ENGLISH VIEW OF NON-RESTRAINT.

In the *Birmingham Medical Review*, for October, 1878, there appeared an article, of which we give extracts below. The author is a man of experience in the treatment of the insane, and his remarks upon a dogmatic "system" of non-restraint, are based upon extensive observation in England and on the Continent.

RESTRAINT IN THE TREATMENT OF INSANITY.

BY G. F. BODINGTON, M. D., F. R. C. P.

"Nil medium est."

"The pendulum of opinion is apt to swing too far. It swings, not seldom, so far beyond its due limit as to come to a dead-lock, and to check the machinery it ought to regulate. When suddenly released, a strong rebound occurs, and it swings again as much too far as it did before, but this time in the contrary direction.

There is, perhaps, no department of human knowledge to which this illustration is inapplicable, no science nor art in which wild views have not at some time or other prevailed, none in which the reaction from wild views has not been productive of mischievous results. *Dum vitant stulti vitia in contraria currunt.* This is not less true of medicine than of other sciences and arts. Possibly, indeed, it is more true of medicine than of most others. The very difficulties met with seem to invite certain minds, of an over-confident and utopian turn, to extremes of opinion and extravagancies of practice. The intricacy and obscurity of the problems to be unravelled, tempt men to plausible explanations, clever hypotheses, and the propounding of well-rounded general laws. The desire to explain the inexplicable, is a passion with many men, to whom a neat theory is better than the best of practical views. Hence we have had, from time immemorial, doctrines, and systems, and schools, and corypheuses in medicine with all their inevitable fruits, a medley of rivalries, hatreds, dogmas and denunciations. These things, however, have for the most part died

out, and practitioners of the art of medicine are now-a-days reputed to be persons of discreet and sober judgment, of well-balanced minds imbued with the true scientific spirit, which takes in all facts, and impartially considers all sides of a question. Medical practitioners have heavy responsibilities. Many grave matters come before them for decision. Life and death are the issues they have to consider. Hence care and caution, in addition to knowledge and scientific training, are expected from them. As a rule the expectation is realized. They themselves have a strong sense of the weight of their responsibilities. Prudent reflection becomes habitual to them. Steadiness of judgment, and a grave habit of mind, grow to be their characteristic qualities. Such persons may be let out of leading strings. Such, surely, are fitted to be entrusted with all remedies and therapeutical means whatever, to employ them at discretion; if not they, then there can be none who are fitted to exercise such functions. But if medical practitioners are fit for such a trust, on what reasonable ground can it be demanded that any class of remedies, or any one remedy or therapeutical agent in particular, shall be forbidden them? Is it conceivable that persons who may be entrusted with nine hundred and ninety-nine remedies, become untrustworthy with regard to the thousandth? Is any one remedy so exceptional that its use must be forbidden to instructed, duly qualified people, who are allowed, without question, to use all others at discretion? The answer is so obvious that the question will be deemed superfluous. It will be said at once that those who may be entrusted, without control, with vast numbers of remedies and curative means—many of them powerful instruments for harm if carelessly or ignorantly handled—may be empowered to use all known remedies and methods without exception. But, it will be exclaimed, there is no exception, all remedies whatever are at the disposal of practitioners to reject or employ them under the sole guidance of their own judgment. This answer, however, requires qualification. Incredible as the statement may seem at the first blush, there is, nevertheless, one means of treatment which is forbidden by certain people in certain quarters, one which is tabooed by authority. To assert this, to say that a particular therapeutical remedy is put under interdict, seems, when barely stated, so extraordinary as to surpass belief. Yet the assertion is true. The allegation that there is an *Index Expurgatorius* of therapeutical means, even though containing but one item, may excite incredulous smiles; nevertheless such an index exists. * * * * *

It is well known that in former days the treatment of insanity was barbarous and brutal. The case has been so thoroughly ventilated that it is enough here merely to allude to it.

From the day when Pinel published his celebrated treatise, a new and a better era began, which has lasted till now. But in this country those who followed in Pinel's steps became, unfortunately, too reactionary. The pendulum of opinion rebounded too far. In removing chains and abolishing cruelties, they abolished altogether mechanical restraint. They propounded a theory and framed a body of doctrine. In short, they established a "system"—the famous "Non-Restraint System," which has flourished uninterruptedly under the patronage and support of official authority from the time of its first promulgation until now."

The author then asserts that the advocates of non-restraint never seemed to imagine that the opposite side had any arguments to advance. "They made it not a question of science, but of orthodoxy and heresy. Men in office do not hesitate, for the maintenance of their own opinions on this question, and for the support of this dogmatic creed, to override the judgment, and denounce the practice of medical officers of asylums, and to dictate a method of treatment of their own prescribing.*

It is not necessary here to marshal all the arguments that have been adduced against the "Non-Restraint System." The main point intended to be maintained in this paper is this, namely, that "Conollyism," to borrow an apt term, completely ignores the consideration that in excluding mechanical restraint from the repertory of medical means and appliances, it may possibly be excluding a valuable remedy calculated to promote the patient's recovery. If this is the case, so far from being a humane system, it is eminently inhuman, for, surely, the first object of medical practice, after prevention, is the cure of disease. The triumph of the physician is not the sublimation of a "system." The recovery of the patient is the triumph of the physician. There is a *primâ facie*

* The whole tone of the Lunacy Reports justifies this remark, but for a flagrant example of interference with the independent judgment of a medical superintendent, see the case at Colney Hatch, recorded in the Twenty-Seventh Annual Report of the Commissioners in Lunacy, 1873, page 20. Dr. Sheppard's reply to the Commissioners is alike unanswered and unanswerable. Their rejoinder is a mere official reproof. No unbiassed mind can fail to perceive that the Commissioners, in interfering in this instance, with the treatment adopted by a duly authorized and responsible medical man overstepped the just limits of their official duties.

cause for suspecting "Conollyism" to be a quackery, for, like all quackeries, it vaunts itself in loud, denunciatory, yet self-asserting tones. It admits no doubts, no deviations from its own dogmas, no tests, no experiments. It is all-sufficient and self-sufficient. Their own wisdom, and the folly of opponents, are in the minds and mouths of its advocates, foregone conclusions. Yet the existing state of lunacy practice may well make him hesitate, who comes to the consideration of the case with an unwarped mind. For such a one there are some ugly facts to be dealt with which can not be glossed over. It is true enough that asylums can be managed, are managed on the "Non-Restraint System" in England, but it does not follow that they are managed in the best possible manner, or the patients so treated as to promote the greatest possible amount of recovery. Lunatics can be regimented, and asylums made places of beauty, snug and shining inside and out, greatly to the delectation of visitors, and the smooth self-satisfaction of official inspectors, who view everything through the dazzling halo of the much cherished "system." The picture is glowing as painted in official reports, but there is a reverse side of it, of sad and sombre hue, a picture of violences, bruising, throttling, crushings and rib-breakings, committed upon insane patients, with a ghastly corner grim with suicides and murders.* Newspaper reports, and the assertions of attendants, as well as the author's personal knowledge, are referred to in illustration and confirmation of the charges of cruelty and abuse under this "system," and the author says: If these things are true, the supporters of the "Non-Restraint System" can hardly be too severely censured or their rosy representations too sharply criticised.

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* In the ten years ending December 31st, 1876, the suicides committed in asylums in England, according to the Reports of the Lunacy Commissioners, were as follows, viz:

1867, 25; 1868, 14; 1869, 20; 1870, 16; 1871, 12;
1872, 29; 1873, 28; 1874, 12; 1875, 21; 1876, 25.

Total 202 suicides in ten years. It can hardly be doubted that a large proportion of these suicides might have been prevented had the certain method of mechanical restraint been relied upon instead of so vacillating, uncertain, untrustworthy a resource as human attention. But the "system" forbids this sure method of guarding the lives of suicidal patients. In addition to these suicides a considerable number of injuries and violences committed upon patients, by attendants, are put on record in the same reports, resulting, in some instances, in death.

It is perfectly evident that a humane treatment of the insane is not yet arrived at, and the advocates of the existing methods in England have to show cause why the glaring evils of the present fashionable treatment should not be laid at their doors. They must indeed confess failure and take a new departure. Otherwise they will have to be driven ignominiously, by force of circumstances, and the inevitable, though tardy logic of facts, from the position of authority, to which, by much boasting and vain-glorious mouthing, they have contrived to attain.

Under any circumstances whatever, that official terrorism which now disfigures and degrades lunacy practice in this country will have to be abolished. Is it to be tolerated, that medical men should be subjected to tyranny about matters of opinion? There are two sides to this question, as to most other questions. On the continent of Europe, and in America, the vast majority of lunacy practitioners, many of them men of world-wide renown, refuse to accept the "Non-Restraint System." The exceptions, indeed, to this are so few that mechanical restraint elsewhere than in England is in all but universal use. Notwithstanding this we have unimpeachable testimony from various quarters that the treatment of the insane is not deteriorated by the practice. Dr. Rogers, for example, uses the following language: "When, too, we regard the practice of other countries, notably of Germany and France, we find that a frequent resort to restraint is by no means commensurate with neglect of the medical treatment of the insane; on the contrary, no nations have contributed more to the literature of insanity in its medical aspects."* In this country, too, there are many practitioners who consistently hold the view that mechanical restraint is an advantage, if not indeed a necessity, in the treatment of insanity. They are, however, overborne by authority, and are hindered from putting their principles into practice by the species of terrorism, especially official terrorism, to which allusion has been made.

The fallacy underlying the position of the anti-restraint party is an example of that common fallacy which consists in arguing from a special case to a general rule, the special case being, in this instance, the inhumanity and worse than uselessness of cruel punishments in the treatment of the insane; the general rule derived

*See President's address at the Annual Meeting of the Medico-Psychological Association, 1874, by Thomas Lawes Rogers, M. D., medical superintendent of the Lancashire County Asylum, at Rainhill.—*Journal of Mental Science*, vol. xx, page 327.

from it is, "Abolish all mechanical restraint whatever." It is as if a man were to say, "My wife always suffers torments of indigestion if she eats pork chops, therefore abolish pork as an article of diet altogether." The non-restraint argument is not at all better than this. Lord Shaftesbury's argument against restraint, in his evidence before the select committee of the House of Commons, is no whit better, when he declares that, "If we ever go back to any portion of it (mechanical restraint), it will become universal, and matters will be worse than they were before."* The *non sequitur* in this passage is palpable.

The question, as a scientific question, is still *sub judice*, and, as long as it is so, those who regard restraint as, in certain cases, beneficial, have an equal right to their opinion with those who regard it as in all cases injurious and unwarrantable. The right of freedom of opinion is now in contest. No party has the slightest shadow of a just pretense to cast a slur on, or to invoke obloquy upon any person or persons who hold different views on such a question as the one now under discussion. Above all, official position confers no divine right to settle the controversy, and the claim of officialism to pronounce judgment *ex cathedra* upon a matter which has yet to be decided on grounds of scientific observation, is pretentious, tyrannical, mischievous and absurd.

"Bien des objections se sont élevées en Angleterre même contre le no restraint pratiqué d'une manière aussi absolue. On a dit que l'usage modéré et temporaire de la contrainte mécanique causait moins d'irritation à l'aliéné qu'une lutte, corps à corps, engagée avec lui; que dans les cas de penchant violent au suicide, ou d'impulsions malfaisantes, cette contrainte, bien plus sûrement que toute surveillance, l'empêchait d'être nuisible à lui-même et aux autres; enfin que le maniaque agité, muni d'une camisole, pouvant sans inconvénient courir en plein air et faire de l'exercice, ce mode de traitement était bien moins préjudiciable à la santé que la réclusion prolongée dans une cellule. On a ajouté que le no-restraint poussé jusque dans ses dernières limites entraînait avec lui de sérieux inconvénients; et dans un rapport adressé au Conseil général des hospices sur les établissements d'aliénés d'Angleterre, M. Batelle a signalé dès 1844, les luttues violentes, les blessures, les homicides même qui lui avaient été signalés dans quelques-uns des asiles qu'il avait visités. Et d'ailleurs pour celui qui envisage la question en dehors de toute préoccupation systématique, les bras

* See "Report, Lunacy Law." House of Commons, July 30th, 1877, page 543, question 11,335.

des infirmiers, les cellules matelassées, ne sont ils pas de véritable moyens de contrainte analogues à ceux qui sont en usage parmi nous? * Thus wrote Professor Marcé in 1862. It does not appear that the years that have elapsed since 1844, thirty-four years of trial of the "Non-Restraint System," have sufficed to eliminate from lunacy practice in England "les lutttes violentes, les blessures, les homicides même" of which Professor Marcé here speaks. The personal vigilance which is declared to be the essence of the "Non-Restraint System" has proved itself a broken reed. If, indeed, it were possible to obtain angels as attendants on the insane, the unintermitting forbearance and unvarying command of temper demanded by Conolly and his followers might have a prospect of realization. But the partisans of the "Non-Restraint System" never seem to recognize nor reckon those ineradicable factors in the calculation, human temper, human impatience, human weariness—in a word, human weakness. Attendants, as drawn by them in pictures of roseate hue, are beings of supernatural type, free from human failings. But, as a matter of fact, such beings as they depict are not to be met with in this sublunary scene. The imaginary attendant of the "absolute non-restraint party," does not exist, and can not be developed from the materials at hand; for the materials are mere human beings. Ordinary human beings constitute the class from which asylum attendants are and must be taken. The partisans of the "system" forget or neglect this fact. The great indictment against them is that they do not confront the realities of the case. They try, on the contrary, to fit everything to theoretical, ideal, imaginary views. Hence their ignominious failure in practice. Hence the reason why, after forty years of full swing of the "Non-Restraint System," forty years of supercilious denunciation of all who have refused adhesion to the orthodox tenets, lunacy practice in England is still disfigured by "les lutttes violentes, les blessures, less homicides même." Hence it is that official reports and non-official newspaper columns teem with records of lunacy scandals—scandals evaded or coolly put aside as "accidents" by visionary enthusiasts wedded to an inflexible incorrigible "system."

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When used protectively mechanical restraint is a humane and a safe means. It is so because it produces infinitely less irritation,

* *Traité Pratique des Maladies Mentales*, par le Dr. L.—V. Marcé, Professeur Agrégé à la faculté de médecine de Paris, médecin des aliénés de l'hospice de Bicêtre; page 215.

anger, discomfort, pain and terror in the patient than manual restraint, even if the latter be ever so judiciously applied. It is so because it can be regulated by the medical superintendent, whereas manual restraint can not be so regulated, being dependent upon the will or caprice of the attendant in charge, who may be bad-tempered; who is sure, in harassing cases, to become weary and who will, in all cases, administer it according to the varying impulse of the moment. Whence it follows that manual restraint can never be regular, equable or certain, and is seldom gentle. Lastly, mechanical restraint is humane and safe, because the instruments of mechanical restraint are free from vices of temper, from impatience, irritability, vindictiveness, passion or tyranny,* because they can neither threaten, nor strike, nor throttle, nor kneel on the chest, nor crush the ribs, nor shatter the breast bone. Thus mechanical restraint is, as now contended, not only a humane and safe means of protection to the patient, but it is calculated to obviate and abolish the cruelties and brutalities that spring out of the practice of manual restraint, that form of restraint in common use by the "non-restraint" party under the flag of the so-called "Non-Restraint System."

So far the protective purpose of mechanical restraint has been the chief subject of remark. But though highly important and useful as a means of protection and safety, there is a still more important purpose for which it may be advantageously employed. As a direct curative means it is one of the best therapeutical remedies at command for procuring that absolute rest so essential in the treatment of acute insanity. "In every case," says Griesinger, "if acute and recent, the primary indication is absolute rest of the brain."† This sentence may be accepted as an aphorism. It contains a cardinal truth as applicable to a brain in a state of functional disorder as to an inflamed knee joint or a fractured rib. By way of instance let us consider acute mania. The restlessness, sleeplessness, constant talking, and incessant muscular movements of this form of insanity are sources of intense exhaustion, which, if not arrested, may sooner or later destroy life. "Exhaustion after acute mania" is one of the commonest causes of death to be found

* "What, again, can be conceived more afflicting to a man who has any intelligence and sensibility left than the vulgar tyranny of an ignorant attendant—a tyranny which the best management can not altogether prevent in a large asylum?"—Maudsley ("The Physiology and Pathology of Mind," Second Edition, page 497).

† "Mental Diseases." New Sydenham Society's Translation, page 464.

in statistical tables of insanity. It may, indeed, be said that when "acute delirious mania" proves fatal, as it frequently does, death is always the result of exhaustion. "It is," says Dr. Blandford, "exhaustion that kills; we do not find by post mortem examination any lesion of the brain or other organ sufficient to cause death."* Conolly himself recognized this danger, and the importance of rest as a means of treatment. "No physician," he says, "of experience in cases of insanity can be unacquainted with the tendency to exhaustion and death in all recent cases of violent insanity, a tendency which struggling with restraints, or the continued excitements unavoidable in a crowd of lunatics, greatly increases, and which silence and rest can alone obviate."† Dr. Bucknill says: "In the first stages of acute insanity all attempts at moral treatment are futile. That which, at this period, is called moral is purely physiological—namely, removal of causes of cerebral excitement, and the arrangement of circumstances so as to secure, as far as possible, a state of cerebral repose."‡ It will, indeed, be conceded by the majority of observers that rest in acute insanity is an essential ingredient in successful treatment. Rest of the disordered organ, that is of the brain, is the primary object to be attained. The question for most of us is, indeed, not whether rest is desirable, but how best it may be procured?

Exhaustion results not alone from disturbance of function of the nervous centers, but likewise from the superadded long-continued exertion of the muscles and motor nerves. "The fatigue of which, after prolonged or unusual exertion, we are conscious in our own bodies, arises partly from an exhaustion of muscles, partly from an exhaustion of motor nerves, but chiefly from an exhaustion of the central nervous system concerned in the production of voluntary impulses."§ If it be true, as here stated, that ordinary fatigue in a state of health is due partly to exhaustion of the muscles and motor nerves, it must likewise be true that exhaustion in states of mental disorder is partially derived from the same source. Anyone who is familiar with acute insanity must, indeed, recognize the fact that the resulting exhaustion is, to a large extent, directly

* "Insanity and its Treatment." Second edition, page 237.

† "The Treatment of the Insane without Mechanical Restraints." 1856; page 43.

‡ Bucknill and Tuke ("Psychological Medicine." Third edition, page 672.)

§ "A Text-Book of Physiology." By M. Foster, M. A., M. D., F. R. S. 1877; page 65.

proportionate with the bodily restlessness and disorderly muscular movement. Hence it follows that if excessive muscular action be subdued, the tendency to exhaustion *quoad hoc* will be diminished. Treatment, therefore, must be directed to securing rest by checking incessant and disorderly muscular movements. Exhaustion being the chief danger, the removal even of a portion of its source is an advantage gained. Lightening the burden may just make all the difference between life and death. But the removal of that amount of the exhaustion merely which is due to over-fatigue of the muscles and motor nerves is not the total gain. If the muscular movements are duly restrained, the "central nervous system concerned in the production of voluntary impulses" is also controlled. So long as muscular movement is possible, voluntary efforts continue, but movement being made impossible, the efforts are discontinued, and the volitional motor centers come to a state of rest. Such, at least, is the case according to the experience of the present writer. Hence it is that we have in the application of restraint a valuable remedy, as previously alleged, calculated to bring the whole of the voluntary motor apparatus into a condition of rest, and thus to obviate the tendency to exhaustion, degeneracy of function, and death.

Much as restraint had been decried as well as banished from practice of late years, its power as a rest producing agent is not wholly unrecognized. Dr. Blandford, for instance, discussing the question of treatment by the wet sheet, says, "It is a powerful sudorific, and promotes sleep by reducing to the minimum the power of motion. There can be no question that when the latter is taken away, patients will often fall asleep. * * * * It will, I presume, be denied by those who use the wet sheet that its chief good arises from its being a form of mechanical restraint; but that it is the latter, for good or evil there needs no argument to prove."*

The "wet sheet pack" was first introduced into asylum practice by Dr. Lockhart Robertson, in the Sussex County Asylum. It was continued by his successor, Dr. S. W. D. Williams. A controversy arose between Dr. Williams and the Lunacy Commissioners, who required the packing to be entered as restraint in the medical journal. This was subsequently done, but under protest, and so strong was Dr. Williams' antipathy to the mere word "restraint," that he confesses that "for many weeks after the visit of the Commissioners no wet sheet packing was prescribed. But,"

* Op. cit., page 231.

he continues, "eventually its absence from our *repertoire* of remedial agents was so much felt, and its partial disuse so powerfully demonstrated to us its usefulness, that at last * * we abandoned our sentiments, and returned to the packing; feeling, indeed, that if we were satisfied of its beneficial effects we had no right to deprive our patients of its advantages." Dr. Williams argues that "to call packing in the wet sheet 'restraint' is a misnomer. The sedative action of cold water is a recognized therapeutical agent, and not long ago the medical papers teemed with reports of cases of disease wherein the temperature is abnormally high, and wherein the cold water bath was used with great effect. This remedy is, however, decidedly heroic, and we prefer to use the much less powerful agency of the wet sheet. But it is none the less a matter of treatment, and should not be designated restraint."* The question whether the wet pack is, or is not, a form of restraint hardly merits serious discussion. Almost all will agree with the Lunacy Commissioners on this point, and with Dr. Bucknill, who says "the wet pack is mechanical restraint of the most stringent character."† The essential question is, whether the mechanical restraint which is undoubtedly applied is the efficient element in the treatment or not. The testimony of men so eminent as Dr. Lockhart Robertson and Dr. Williams gives this therapeutical remedy a high claim to consideration. Its efficacy is said by them to depend upon causes quite independent of the coercion unavoidably exerted. But the mechanical restraint, or coercion, or "passive resistance," or whatever euphemism the thing may be described by, is there. It exists, and may possibly contribute to the beneficial effect. The question is whether the observed results are due to the water or to the restraint, or to both combined. The way to solve the question is to use the two things separately, not so easy to do with regard to the water, but easy enough with regard to the restraint. Dry packing may be employed. It is quite true that if dry packing be effected by a quantity of heavy envelopes, blankets, counterpanes, or what not, the heat of the body is retained, the circulation is at first quickened, the face becomes flushed, and sweating more or less profuse, according to circumstances, speedily ensues in most instances. Dry packing so managed differs little in its results from wet packing. It is like the latter, a powerful sudorific, and, of course, it is open to anyone to

* "The Journal of Mental Science," October, 1873. Vol. xix, page 452.

† Bucknill and Tuke (op. cit., page 654.)

say that part at least of any observed favorable results may be due to the increased action of the skin. But dry packing may be effected by means of materials of such a texture as not to produce sweating, and, indeed, may easily be so applied as to require the usual supply of blankets to maintain warmth. Under such circumstances the sudorific effect goes, of course, out of the calculation, and the restraint alone remains as the efficient remedial agent.

Dry packing used in this fashion will be found to produce the beneficial results claimed for the wet sheet. When once a maniacal patient feels that all resistance is useless, the effort at resistance, as previously pointed out, ceases, and sleep frequently ensues without any other treatment. The whole system, bodily and mental, comes to a state of much-desired rest. Even if sleep does not immediately supervene, a great advantage is gained in the mere quietude procured. But this advantage is supplemented by another of very great importance. It will be found that hypnotics act more quickly, more effectually, and in much smaller doses on a patient who is properly restrained than on one who is allowed to continue in a state of restlessness.*

As to the method of applying the pack, wet or dry, little need be said. A good description of the wet pack is given in Dr. Johnson's work on hydropathy.† In cases of violent mania some means, it is presumed, must, as a rule, be adopted of fastening the sheets and blankets to prevent the patient from setting himself free. In dry packing a very strong sheet or a thin but strong counterpane is used. The patient, wearing only a night-dress, is laid upon this, the arms being placed straight down by the side. It is then wrapped firmly round the body and fastened by being sewed up, from the neck to the feet, with stout thread.

* This, of course, is a fact of no weight with those who see no advantage in producing sleep. Dr. George H. Savage has recently declared, ("Guy's Hospital Reports," Third series, vol. xxiii, 1878, page 141) that, "The mere producing of sleep does little if any good in the majority of cases of insanity," and he relies chiefly, (page 164,) on *moral* treatment "by means of the right mental levers," whatever those implements may be. Few authorities, probably, will concur in this view. Dr. Bucknill, for instance, (op. cit., page 734), says, "It is, and must be, a great point gained that a patient suffering from acute mania should have a good night's sleep secured for him." Dr. Blandford, again, (op. cit., page 230), speaking of acute delirious mania, says, "But many of these cases are cut short and cured like delirium tremens if we can procure one long and sound sleep."

† Quoted in "Ringer's Handbook of Therapeutics." Third edition, page 31.

It may be here incidentally observed that neither packing nor any kind of restraint is ever to be used as a punishment. It is only advocated now as a protective measure and as a remedial agent. *It is taken for granted that it is only to be applied under the authority and direction of authorized medical practitioners, and no more to be left to the discretion of attendants than the administration of chloral, or morphia, or antimony, or any other medicinal remedy whatever.* Patients when packed are not to be left alone.

Patients when packed ordinarily lie quite still, but it happens sometimes that they rise up in bed or writhe about. If this were allowed to continue the object of the packing would be frustrated, the restraint being only partial. The restraint to be effectual must be complete, and it is requisite, therefore, under such circumstances, to fasten the patient to the bed. The best way of doing this is by passing a band of broad webbing across the chest and shoulders, and entirely round the bed, tying it underneath the bedstead, or at one side. A similar band may, if necessary, be passed across the knees. This latter, however, is seldom required, for patients unable to move their arms, and unable to rise in bed, cease immediately to struggle, and relapse into calmness and quietude. It need hardly be stated that the recumbent posture is the one invariably to be adopted when packing is employed.

Now, it is not intended to lay down dogmatically what has been here asserted with regard to this mode of treatment. The question of treatment by restraint, like that of all other modes of treatment, must be settled, in the long run, by close and accurate clinical observations, made by numerous observers. The statements of a single observer can not be accepted unless confirmed by others. No claim is now made for acceptance of the mode of treatment under discussion upon the *ipse dixit* of one man. But the treatment is advocated in the hope that it will be fairly examined and tried upon a large scale in large asylums. The inferences drawn with regard to it have been taken from experience gained in a small private asylum over a period of eleven years. The experience so gained has taught this lesson, at any rate, namely, that in the same hands, under the same general methods of management and treatment, acute mania has been much more successfully treated with mechanical restraint than without it.

In conclusion, it is hoped, nay, entreated, that this matter of mechanical restraint may be looked into and examined without prejudice or foregone conclusions, that it may, where tried, be put

in practice fairly and fully, not carelessly nor in a perfunctory manner, and not tossed on one side without giving it a complete test. Above all, it is earnestly wished that asylum superintendents and medical officers may utterly and finally repudiate and spurn every vestige of official terrorism or dread of being charged with heterodoxy, so that the subject in question may be investigated in a truly scientific spirit, without fear and without favor.

BOOK NOTICES.

Habitual Drunkenness and Insane Drunkards. By JOHN CHARLES BUCKNILL, M. D., London, F. R. S., F. R. C. P., Late Lord Chancellor's Visitor of Lunatics. London: Macmillan & Co., 1878.

The above monograph is a republication, in book form, of letters and addresses, upon the cure or reform of habitual drunkards, and is the result of a late attempt to induce the British Parliament to pass acts making the forcible commitment to, and detention in, Inebriate Asylums, of habitual drunkards possible. The parties who attempted to secure parliamentary aid, acted upon the dictum of the American Association for the care of Inebriates, and asserted that when developed to its full extent, "habitual drunkenness is no longer a vice but a disease," and it is to this assertion that Dr. Bucknill directs the force of his arguments.

Dr. Bucknill says:

"The great mistake which Dr. Cameron (the advocate of the bill) and his friends make, is in refusing to recognize the obvious and undoubted fact, that there are two distinct kinds of drunkards—the habitual and the insane drunkard—who must be dealt with by different methods; the one form of drunkenness being a mere vice which may be reformed by moral methods. * * * This kind of drunkenness is too wide-spread to be dealt with in asylums, or in brick and mortar institutions of any kind. Neither can it be cured by any form of treatment, for it is not a disease. The other form of habitual drunkenness is a morbid condition, and is, in fact, a form of insanity." * * * * *

The author is convinced that he speaks with the concurrence of all well informed members of his profession, when he asserts that a man who has become a

drunkard, after a sunstroke or a blow on the head, his craving for drink being accompanied by such other indications of mental infirmity, as Dr. Cameron has specified, and in whom Dr. Cameron is perfectly right in supposing that there are structural alterations of the nervous system, must, under any methods of treatment at present known to us, be looked upon as a lunatic, presenting an exceedingly small probability of permanent cure. For this class, the author, owing to the long remissions of the more marked symptoms, which renders insane drunkards inconvenient inmates of ordinary lunatic asylums, would establish public hospitals for insane drunkards.

For ordinary drunkards Dr. Bucknill advocates a wider and sharper application of punishment than is now practiced. He says:

"The overt acts of the drunkard ought to be punished in such a way as to make them a real warning, and especially the act of public drunkenness, which is a kind of indecent exposure; also failure, through drunkenness, to maintain children, and, indeed, all drunken conduct which invades the rights of others, and there can be no just reason why the punishment for such acts should not be accumulative. It is unreasonable that magistrates should have to commit the same person from fifty to a hundred times, for a constantly repeated offense, the remedy for such would appear to be a penitentiary for habitual drunkard offenders, in which they should be compelled to earn their maintenance, and from which they should be released on trial, and live for a time under the surveillance of the police."

His remarks are very aptly prefaced by the assertion that as habitual drunkards are manufactured from occasional drunkards, why not attack habitual drunkenness at its source?

The Doctor most emphatically disclaims any belief in the assertion that over sixty per cent of the patients who had been treated in a certain inebriate asylum,

during five years, and who had remained under treatment four or five months, had been reformed. Regarding the assertion of an "American inebriate doctor," vaunting the absolute cure of thirty-four per cent of diseased drunkards, he says: "when some of these institutions, moreover, are supported by public funds, and the gentlemen making these statements are public functionaries, then the position seems to be changed, and any one and every one seems to have the right to inquire into the credibility of such statements."

In view of these remarks, and of his assertion that the consideration and treatment of habitual drunkenness, as a disease, has, in America, proved a failure, Dr. Bucknill will be interested in the following extract from the last annual message of Governor Robinson, of this State.

"From conversation with several of the leading managers of the New York State Inebriate Asylum, I learn that they consider the experiment for the reformation of inebriates, as hitherto tried in the Asylum at Binghamton, a complete failure. I have long been of the same opinion. The law does not, and perhaps can not, properly provide for the forcible arrest, detention and control of inebriates. Consequently there are no patients at the asylum except such as consent to go there voluntarily. There is no power to restrain them of their liberty, and the institution has become practically nothing more than a hotel for the entertainment of wealthy inebriates, who remain there so long as they find it pleasant and agreeable, and when it ceases so to be, they leave it without anything approaching a permanent removal of their appetite for intoxicating drinks. The institution must, therefore, be regarded as having wholly failed to accomplish the laudable purposes for which it was undertaken, and to realize the high hopes on the part of the public for its success. I recommend that no further appropriations be made towards its support, for its original purpose. The building is a spacious and convenient one, with a large farm attached to it, and it may, without much expense, be changed into a very commodious asylum for the insane who are now confined in county poor-houses, and generally not well cared for, and for

whom there is not sufficient room at the Willard Asylum. I understand the Board of State Charities approve of this disposition of the building. I commend the subject to your careful consideration."

Dr. Bucknill has, in this republication of his remarks, addresses and letters, upon the subject of habitual drunkenness, done a good service to social economy, as well as to the cause of psychological medicine.

Nervous Diseases: Their Description and Treatment. By ALLAN McLANE HAMILTON, M. D., Fellow of the New York Academy of Medicine; One of the Attending Physicians at the Epileptic and Paralytic Hospital, Blackwell's Island, N. Y., etc., etc. 8 vo., pp. 512, with 53 Illustrations. Philadelphia: Henry C. Lea, 1878.

The author of this work, in attempting "to produce a concise, practical book," has appointed to himself a task which, in the special department of which he treats, requires clear judgment, accurate observation, and an intelligent appreciation of the wants of his readers. On the treatment of nervous diseases there are books and books; some have been written apparently from the standpoint of speculative and theoretical views of pathology and treatment; others are so special in their direction as to be unsuitable for the general practitioner; and others again would seem to be written from a speculative point also, but the speculation has been directed to securing reputation and patients, rather than toward an exact and scientific elucidation of the topics under consideration.

The work produced by Dr. Hamilton is, in many respects, the best work yet produced on the subject, by an American writer. The author can hardly be said to have written a "Treatise" upon nervous diseases, but he has produced, what is still better in a practical sense—a concise text-book. The introduction instructs the reader in what and how to observe, and the

methodical record of observations made in cases of nervous disease; gives directions for post-mortem examination, and explains the application of the various instruments used in diagnosis, viz.: the thermometer, æsthesiometer, dynamometer, dynamograph, ophthalmoscope, electrical apparatus, etc. Dr. Hamilton, very properly we think, places no reliance upon the ophthalmoscope in diagnosis of disturbances of the cerebral circulation, and says of it: "*I do not believe that it possesses any value in the diagnosis of brain diseases, except when the condition of the fundus is the result of an organic disease of the brain or cord.*" Following the introduction there are eighteen chapters which treat of the following topics:

Chapter I, Diseases of the Cerebral Meninges; Chapters II to VII, Diseases of the Cerebrum and Cerebellum; Chapter VII, Diseases of the Spinal Meninges; Chapters VIII to XI, inclusive, Diseases of the Spinal Cord; Chapter XII, Bulbar Diseases; Chapters XIII and XIV, Cerebro-Spinal Diseases; Chapters XV to XVIII, Diseases of the Peripheral Nerves. A few pages at the end are occupied by Formulae.

The chapters upon diseases of the meninges are well, and in the main, carefully written, although occasional evidence of haste shows itself. Under this head is included some remarks upon cerebro-spinal meningitis, which the author includes on account of "its interesting diagnostic relations." Nearly thirty pages are devoted to cerebral hæmorrhage, and they form one of the most interesting portions of the work. The author very wisely, we think, refuses to accord to athetosis the dignity of a distinct disease, in this agreeing with Charcot, Gowers and others.

The author, as would be expected from one occupying his position, makes some excellent remarks upon epilepsy. We wish that every practitioner could be

made to appreciate the strong ground which he takes against the routine treatment by Bromides, and to act upon the excellent suggestions which he makes concerning tonic and supporting treatment. The readers of our excellent cotemporary, the *American Journal of Medical Sciences*, will find the article on hysteria familiar, it having been published almost exactly as it now appears in that journal some time since.

Very properly, we think, Dr. Hamilton has refrained from any consideration of insanity. The limits of a text-book upon nervous diseases are altogether too small for the proper elucidation of even the most prominent divisions of what has come to be a special department of neurological study. The text is well illustrated by cases drawn from the author's practice, and a number of wood cuts, most of which are well made. We conclude this notice by reiterating our first impression, that the author has produced a concise and practical text-book on nervous diseases which, in many respects, is the best yet written in the English language.

On Rest and Pain. By JOHN HILTON, F. R. G., F. R. C. S. Second Edition. Edited by H. A. JACOBSON, F. R. C. S. Cloth, 8 vo., pp. 299, with illustrations. New York: Wm. Wood & Co., 1879.

This work is the first of the series of Wood's Library of Standard Medical Authors. The work is well known abroad, and its value is a matter beyond discussion. Messrs. Wood & Co. have made an excellent selection as introductory to their Standard Library, and if the future volumes are of equal merit, they will justly deserve the lasting obligations of the profession. The work of Dr. Hilton, in the form of lectures, and in an English edition, has been, for some time, before the profession; it has, however, obtained but comparatively few readers on this

side of the Atlantic. The author treats of mechanical and physiological rest in medical and surgical diseases, of pain, its relief, and its diagnostic value. He presents his facts in a clear and concise manner, and draws his conclusions in a style at once simple and logical. His observation upon "Rest and Pain," are of importance and value, and should be read and applied by every practitioner. The work is presented in a handsome form, much more so, in fact, than we supposed possible at the price. The scheme which the publishers have thus inaugurated, is to publish twelve standard medical works a year, one being issued each month. The entire set being sold to subscribers for the moderate sum of twelve dollars, payable in advance. A circular giving the names of the forthcoming works in the series, with terms, etc., can be obtained, on application, of the publishers, Messrs. Wood & Co., New York.

Deterioration and Race Education, with Practical Application to the Condition of the People and Industry. By SAMUEL ROYCE. Boston: Lee & Shepard, 1878.

We hardly know what to say of the work before us. The author is evidently one of those unhappy mortals who sees everything in morals, physical and mental health, justice and civilization, gradually tending toward a general chaotic condition. We should be very loth to believe that the dark picture which he draws of the present condition of the laboring classes, and the future to which he thinks they are hurrying, is anywhere near exact, and from a long and practical observation of their status we do not believe it is. We do believe that improvidence, ignorance and, above all, *injudicious charity*, do much toward preventing the laboring classes from rising above their position, and

we welcome and say God-speed to any man who, in any way, proposes to educate them into a better way. We are glad to see that charity is becoming organized in its efforts to relieve the unfortunate—that the really needy are sought out, and impostors and social barnacles are punished. That the race is deteriorating we do not believe; that hereditary diseases are carrying off our population we can not admit, until better proof is adduced than our author has to offer. On the contrary, there never was a time when the death rate was lower than at the present; when preventable diseases were better understood, or when human life was held in greater respect or enjoyed with greater safety.

Much that the work under consideration contains is interesting and valuable, and to the student of social economy the author has many instructive facts to present; but much, also, consists of the repetition of platitudes upon the condition of the pauper and criminal classes, social and moral reforms, industrial education, the prevention and punishment of crime, etc., etc. The book will find many readers—in fact, from the testimonials which accompany it, it has already been received with much favor; among practical educators, to whom we must look to cure or prevent much of the “deterioration” which the author bemoans, it will be studied with interest and profit. We notice a few proof errors, among the most serious of which is the conversion of our learned and genial friend, Dr. Thomas F. Rochester, into Dr. Thomas F. Hunter.

Ueber die Lehre Von der Entwicklung der Ganglien des Sympathicus. Von Prof. Schenk und Dr. W. R. Birdsall, aus New York. (Separat Abdruck aus den Mittheilungen des Embryol. Institutes, III.)

This is a very interesting contribution to the literature of so important a department of medical science,

as the development of the nervous system, and the views expressed, sustained by accompanying drawings of microscopic preparations, are quite conclusive. The authors assert that the sympathetic system is developed from the cerebro-spinal, and their arguments and deductions but add to the many assertions, that all nervous tissue arises solely from the epiblast. The explanations and demonstrations regarding the formation of the cardiac, solar, sacral and Auerbach's plexuses, are logical and natural. The drawings which accompany the text are well made, and are by no means the least interesting portion of the monograph.

S U M M A R Y.

—Dr. Alfred T. Livingston, after five years' service as one of the medical officers of the N. Y. State Lunatic Asylum, at Utica, resigned on October first, 1878, to enter into general practice in the city of Philadelphia.

—Dr. Edward N. Brush, who had been acting as fourth assistant since March, 1878, in the absence of Dr. T. F. Kenrick in Europe, was appointed third assistant.

—Dr. W. W. Miner, of Buffalo, was appointed to the position of fourth assistant, during the further absence of Dr. Kenrick in Europe.

—On December 31st, 1878, Dr. W. E. Ford resigned the position of second assistant, at the N. Y. State Lunatic Asylum, to enter into general practice in the city of Utica. Dr. Ford had been connected with the Asylum, as assistant, since 1873.

—We are pleased to learn that the Pennsylvania Hospital has opened its well furnished pathological laboratory to the profession. Dr. Morris Longstreth, the pathologist of the Hospital, will be in charge.

—The New York Medico-Legal Society have commenced the publication of a *Bulletin*, under the able editorial conduct of Dr. George W. Wells. The *Bulletin* will be furnished to members free; to others the price is fixed at \$2.00 per year.

—Messrs. Lindsay & Blakiston will accept our thanks for a copy of their excellent visiting list. To the general practitioner a visiting list is indispensable, and that published by the above firm has come to be a general favorite. We have also, awaiting review, several valuable works from the press of this well known house, which we regret not being able to notice in this number.

—Mr. Henry C. Lea, medical book publisher, of Philadelphia, sends us an announcement of some of the more important works about to be issued from his press. Among them we notice "The National Dispensatory," edited by Alfred Stille, M. D., of the University of Pennsylvania, and John M. Maisch, Ph. D., of the Philadelphia College of Pharmacy; a second edition of "Ashurst's Surgery," and a second American edition of "Bryant's Practice of Surgery;" a translation by Dr. E. O. Shakespeare, of "Conril and Ranvier's Pathological Histology;" and a work on "Human Anatomy," by Prof. Harrison Allen, M. D.

—The *Index Medicus* is the title of a monthly publication, the first number of which is to be issued during the month of January, by Mr. F. Leypoldt, of 37 Park Row, New York. The *Index* will be under the editorial management of Dr. Billings, Librarian of the Surgeon General's office, and his assistant, Dr. Robert Fletcher. It will give an index of the leading medical journals in the English and other languages, and notice, by title, all new publications in medical science. The publication of a periodical of this character should be heartily encouraged, as it will be invaluable to students of current medical literature.

STATE COMMISSIONER IN LUNACY.

HIS JUDICIAL AUTHORITY DETERMINED.

SUPREME COURT—KINGS COUNTY.

IN THE MATTER
OF THE
KINGS COUNTY ASYLUM.

*On Demurrer to Jurisdiction
of State Commissioner in
Lunacy, and order to show
cause on proceeding for
contempt.*

September 21, 1878.

OPINION.

GILBERT, J.—This is, as it seems to me, a plain case, and it probably would not have been presented to the Court, but for a misconception on the part of the Commissioners of Charity, of the relation which they bear to the State Commissioner in Lunacy. No doubt the general management and administration of the Asylum, including the selection, appointment and removal of persons employed in carrying on the several departments thereof, has been intrusted to the Board composed of said commissioners. But the exercise of their powers is, in a large degree, subject to the supervision and control of the State Commissioner in Lunacy, and the latter is authorized to require the Board to conform in their management of the Asylum to such orders and directions, as he may, from time to time, give to them for the purpose of remedying evils, or defects, which have been proved to him to exist in such management, and which are injurious to the lunatics committed to their care. The statute from which the State Commissioner in Lunacy derives his powers, is broad and comprehensive. It is his duty to examine into the condition of the insane and idiotic in the State, and the management and conduct of the asylums, public and private, and other institutions for their care and treatment, and the officers and others respectively in charge thereof are required to give such commissioner, at all times, free access to, and full information concerning the insane therein, and their treatment. In all cases where, from evidence laid before him, there is reason to believe that any person is wrongfully deprived of his liberty, or is maltreated in any asylum, institution or establishment, public or private, for the custody of the insane; or whenever there is inadequate provision made for their skillful medical care, proper super-

vision and safe keeping, he is empowered to institute a formal inquiry, of a judicial nature, into the matter, and for the purposes of such inquest he is authorized to issue process to compel the attendance of witnesses and the production of papers, and to enforce obedience to such process, and while conducting such inquest he is invested with the same powers as belong to referees appointed by this Court. The functions of the Commissioner in Lunacy, in respect to such inquest, are analagous to those of a grand jury. But he is not required to exercise them in all cases. Where testimony can be obtained voluntarily it may be taken by the Commissioner in that way, and the formality of an inquest may be dispensed with. The holding of an inquest is only for the purpose of obtaining evidence compulsorily, (Laws 1874, Chapter 446, Title 10, as amended by Laws 1876, Chapter 267). If either of the above mentioned facts shall be proved to his satisfaction, in either of the modes pointed out, he is further empowered to issue an order in the name of the people of this State, and under his official hand and seal, directed to the superintendent or managers of such institutions, requiring them to modify such treatment or apply such remedy, or both, as shall therein be specified. These extensive and *quasi* judicial powers have been conferred upon the Commissioner in Lunacy for the beneficent purpose of protecting a helpless class of citizens against ill usage, and of securing to them the benefits of the care and treatment which the State has immemorially provided for them. The question, "Who shall guard the guardian?" is a pertinent one at all times, and especially to custodians of the insane. I entertain no doubt of the power of the Legislature to confer such powers, and I think they should be liberally interpreted in furtherance of the object mentioned. (People ex rel. N. Y. Inebriate Asylum vs. Osborn, 57 Barb., 663). In the case before me a reputable citizen of Brooklyn made a deposition voluntarily before Dr. Ordronaux, the State Commissioner in Lunacy, on the 20th of August last, showing in substance that the Commissioners of Charities had directed a change to be made in the office of Medical Superintendent of the Insane Asylum by the removal of Dr. Parsons without any cause therefor, and the appointment of Dr. Shaw, who had had no special experience in the treatment of the insane. Dr. Ordronaux thereupon issued an order directed to said commissioners, whereby, after reciting the substance of said deposition, that frequent changes in the chief medical officer in asylums for the insane are calculated to impair that skillful medical care and supervision which is derived from

long personal acquaintance with and study of the individual phases of insanity, and that such changes in the Kings County Asylum had been frequent, he commanded said commissioners to retain Dr. Parsons until good and sufficient cause should have been shown to them for his removal. The commissioners made a return to this order, in which they denied the jurisdiction of the State Commissioner in Lunacy, and also that the removal of Dr. Parsons would have the effect stated in the order, and insisted that the interference of the State Commissioner in Lunacy with their power to make such removal was an intrusion into the domain of their jurisdiction. I am of opinion that the commissioners were in error on all of the points taken in their return—Dr. Ordronaux acquired jurisdiction to make the order by virtue of the deposition referred to. That contained facts which tended to show that the commissioners had made inadequate provision for the skillful medical care of the insane under their charge.

The evidence was competent, and taken in a proper manner—of its sufficiency Dr. Ordronaux was made by the statute the sole judge in the first instance. Having jurisdiction to make the order, it was the duty of the Commissioners of Charities to obey it. If they had disobeyed the order it would have been the duty of the Court to compel a performance thereof in the summary mode pointed out by the statute, unless they showed sufficient cause why said order should not be performed. I am of opinion, however, that no disobedience of the order of Dr. Ordronaux has been shown. The commissioners were required to retain Dr. Parsons only until good and sufficient cause for his removal should have been shown to them. It appeared, on this hearing, that the removal of Dr. Parsons was, in fact, made for cause, and as I have already intimated, if such cause had been set forth in the return of the Commissioners of Charities to Dr. Ordronaux's order, that would have put an end to this proceeding. While I am glad to say that the reasons assigned for the removal of Dr. Parsons do not affect his qualifications as a physician, or as a specialist in the treatment of the insane, yet they must, for obvious reasons, be deemed by me good and sufficient. It may be added that it was both conceded and proved that Dr. Shaw is in all respects competent for the position of medical superintendent.

The motions arising upon the orders granted by me must, therefore, be denied, and all orders restraining the removal of Dr. Parsons are vacated, without costs.

—The readers of the JOURNAL have been informed by general publications, which have appeared through the secular and medical press, as well as by the announcement of Dr. William A. Hammond, in an open letter, addressed to Dr. Eugene Grissom, of North Carolina, that Dr. Hammond has sued the editor of this JOURNAL for libel, in connection with the publication of the paper of Dr. Grissom on "True and False Experts," which he read before the Association of Superintendents, in May last, and which appeared in this JOURNAL as part of the proceedings and transactions of that body, at its meeting held in Washington. This JOURNAL has published the proceedings, and most of the papers read at the meetings of the Association, for more than thirty years. As the readers are aware, from the proceedings, the essay of Dr. Grissom was read on the evening of the 15th of May, 1878, before the Association, in Willard Hall, Washington, by appointment of the Association, a large number of auditors being present beyond the members of that body.

It was brought up for discussion, in its order, on the seventeenth, Dr. Gray, however, not being present. Dr. Wallace, of Texas, opened the discussion, and offered a resolution asking the censure of Dr. Grissom, and declaring that the article was personal. The remarks of Dr. Wallace contained an innuendo that Dr. Grissom was put forward by others. The resolution, after discussion, was laid upon the table.

So much of the discussion as was furnished by the Secretary to the JOURNAL, appeared in the proceedings in the July number. The remarks of Drs. Ray and Hughes were sent by the Secretary after the October number was printed, and appear in the present number, together with a resolution by Dr. Kirkbride. We have heretofore abstained from editorial comments:—

First. Because immediately after the meeting of the Association, Dr. Hammond, himself, in an open letter, assailed Dr. Grissom and his paper, in a communication almost as long as the essay of Dr. Grissom, which naturally was received as Dr. Hammond's answer.

Second. Dr. Grissom, himself, then immediately published his paper on True and False Experts.

Third. Dr. Hammond then published a second edition of his open letter, with preface and postscript. In this he referred to the action of the Association, and gave the resolution of Dr. Wallace, with the names of those who had voted for it. All this was before the appearance of the JOURNAL, showing that Dr. Hammond had received information directly from the Association or its members, and that the second edition was his further answer.

Fourth. The discussion was had in the Association, and Dr. Wallace's resolution, with his remarks, were before the readers of the JOURNAL. The insinuations of Dr. Wallace, in his remarks, as printed, pointed to others than Dr. Grissom as the author, of whom, however, we disclaim any knowledge. We have never had any communication with Dr. Wallace upon the subject, and do not know upon what knowledge or information he made his insinuations; as far as the editors of this JOURNAL are concerned the insinuations are groundless. It is proper to add, in justice to Dr. Grissom, as well as to the editors, that they never furnished a single fact, suggestion or intimation, to Dr. Grissom, touching the subject or subject matter of his address on "True and False Experts." As far as the editors of this JOURNAL knew then, and know now, and believe, the paper was solely Dr. Grissom's, an entirely responsible member of the Association.

Finally. We have not been in the habit of editorially commenting upon the papers read before the Association, when printed in this JOURNAL. The editors, in view of the fact that the article of Dr. Grissom was wholly his own, was publicly read before the Association, and was discussed and sustained by that body, and was sent to this JOURNAL for publication, in accordance with long established usage in such cases, are certainly relieved from any imputation of wrong, or even discourtesy, towards Dr. Hammond, or any one else. Indeed we should hesitate to refuse a paper read before the Association, by one of its members, upon the topics which it assembles to discuss, and which was accepted and endorsed by that body; when the publication is under the name of the party responsible for its contents, and is in effect part of the report of public proceedings of the highest interest to the profession.

The view generally taken by the press, thus far, has been that Dr. Hammond would have better consulted his dignity and his reputation to have directed his attack against the authors of any statements by which he may deem himself aggrieved, than to commence a litigation against the editors of this JOURNAL, who simply perform what they deem to be their duty, in giving to the profession any and all of the papers or proceedings of a public body in which it has an especial interest.

The following was received from Dr. John Curwen, Secretary of the Association, after the October number was in type, with a note, saying that the members named desired the insertion of the remarks in the JOURNAL.

Dr. RAY. I seconded the resolution, and I intend to vote for it unless a better substitute is offered. I did not hear the essay. I

heard of it, however, and I felt exceedingly sorry that it was read here. As to whether the censure in it were just or unjust, right or wrong, I do not express an opinion. If Dr. Grissom thought the attack was well founded, he had the right to publish it in a newspaper or a journal if he pleased, but I do contend that he had no right to bring it in here. We have no right to sanction personal attacks. It was a personal attack, surely, to call a person virtually a charlatan, however true it might be. We may disclaim responsibility for anything said here by individual members, but we can not shake it off. If a paper is read here we uphold it to a certain extent, and if it is objectionable on personal grounds, we are bound to utter a protest against it.

Perhaps what we have said here is sufficient for our purpose, but it will not go any further. But the essay will be printed, and go to the ends of the earth, it may be.

Dr. Hughes, after stating that although the paper of Dr. Grissom was not such a paper as he might have prepared himself, had no disposition to define the manner in which gentlemen might see proper to present their thoughts to the Association, said the resolution of Dr. Wallace was out of order, the society being engaged under a previous resolution in this, a three minutes' discussion of the several papers in their order.

After the resolution was laid on the table, Dr. Kirkbride offered the following resolution, which was seconded by Dr. Grissom, and was unanimously adopted:

Resolved, That this Association reaffirms its declarations made on previous occasions, that it holds itself in no way responsible for any paper read before it, or for any sentiments expressed in its meetings, unless from a direct vote of the Association.

OBITUARY.

Dr. BENJAMIN WORKMAN.—On the 26th of September, 1878, Dr. Benjamin Workman died, at his residence, Uxbridge, Ontario, in the eighty-fifth year of his age. Dr. Workman was born in Ireland, in 1793, and in 1819 came to this country and settled in Montreal, where he conducted, for several years, a very successful school. In 1852 he took his degree of M. D., and in 1856 was appointed assistant to his brother, Dr. Joseph Workman, in the Toronto Insane Asylum, which position he filled with rare fidelity, intelligence and zeal, until 1875, when failing health compelled him to retire. For some years Dr. Workman had labored under a chest trouble which had been diagnosed as thoracic aneurism, and the ultimate cause of his death, hemiplegia, which ended fatally in twenty-four hours, was probably due to a clot being carried from the aneurismal sac into the cerebral circulation. Dr. Workman was a man of extensive professional and literary attainments, an earnest student, and a noble example of the quiet, unassuming Christian gentleman. He leaves behind him an enviable record of simplicity, energy and devotion.

Dr. WILLIAM M. COMPTON.—Among the victims to the dreadful scourge of yellow fever, which has just swept over the South, it becomes our painful duty to announce the name of Dr. William M. Compton, who died at Holly Springs, Miss., October 1st, 1878. We are informed that Dr. Compton's entire family died of the fever. Owing to want of suitable data, we shall defer, until a subsequent number of

the JOURNAL, any extended notice of our deceased brother. He was an active and earnest member of the Association of Superintendents of Insane Asylums, and was regarded by all his associates as a genial, brave and kind hearted physician. In June last he was elected Chairman of the Section of Psychology, Medical Jurisprudence and Chemistry, of the American Medical Association, a position which he would have filled with honor to himself and credit to the Association. In the JOURNAL for October, we announced the intention of Dr. Compton, to open a private asylum for the insane, at Holly Springs about December first, but alas! before that time approached, our genial associate had passed beyond all earthly labor and was at rest.

BOOKS, PAMPHLETS, &c., RECEIVED.

Nervous Diseases: Their Description and Treatment. By ALLAN McLANE HAMILTON, M. D., etc., etc. Philadelphia: Henry C. Lea, 1878.

Notes on the Treatment of Skin Diseases. By ROBERT LIVEING, A. M., M. D., Cantab. New York: Fourth Edition: Wm. Wood & Co., 1878.

Essentials of Chemistry. By R. A. WITTHAUS, A. M., M. D. New York: Wm. Wood & Co., 1879.

On Rest and Pain. A course of lectures on the Influence of Mechanical and Physiological Rest in the Treatment of Accidents and Surgical Diseases, and the Diagnostic value of Pain. By JOHN HILTON, F. R. S., F. R. C. S. Edited by W. H. A. JACOBSON, F. R. C. S., Assistant Surgeon to Guy's Hospital: Second Edition. New York: Wm. Wood & Co., 1879.

Diseases of the Bladder and Urethra in Women. By ALEXANDER J. C. SKENE, M. D., etc., etc. New York: Wm. Wood & Co., 1878.

Lectures on Localization in Diseases of the Brain. By J. M. CHARCOT, Professor in the Faculty of Medicine in Paris, etc., etc. Edited by BOURNEVILLE. Translated by EDWARD P. FOWLER, M. D. New York: Wm. Wood & Co., 1878.

Lectures on Bright's Disease of the Kidneys. By J. M. CHARCOT, Professor in the Faculty of Medicine of Paris, etc., etc. Collected and published by Drs. BOURNEVILLE and SEVESTRE. Translated by HENRY B. MILLARD, M. D., A. M. New York: Wm. Wood & Co., 1878.

A Manual of Physical Diagnosis. By FRANCIS DELAFIELD, M. D., and CHARLES F. STILLMAN, M. D. New York: Wm. Wood & Co., 1878.

Habitual Drunkenness and Insane Drunkards. By JOHN CHARLES BUCKNILL, M. D., F. R. S., etc., etc. London: Macmillan & Co., 1878.

Journal of Insanity.

The Superannuation of Officers in British Hospitals for the Insane; Its Principle, Policy and Practice. By W. LAUDER LINDSAY, M. D., F. R. S. E., etc., etc. London: J. & A. CHURCHILL, 1875.

History of the Murray Royal Institution for the Insane, Perth, from its establishment in 1827, to the end of the first half century of its existence in 1877. By W. LAUDER LINDSAY, M. D., F. R. S. E., Physician to the Institution. Perth: 1878.

"*Excelsior.*" The Literary Gazette of the Murray Royal Institution, Perth. Perth: 1878.

The Cell Doctrine; Its History and Present State. For the use of Students in Medicine and Dentistry. Also a copious Bibliography of the subject. By JAMES TYSON, M. D., etc., etc. Second Edition, illustrated. Philadelphia: Lindsay & Blakiston, 1878.

Practical Surgery; Including Surgical Dressings, Bandaging, Ligations and Amputations. By J. EWING MEARS, M. D., etc., etc., with illustrations. Philadelphia: Lindsay & Blakiston, 1878.

Giles & Co., or Views and Interviews concerning Civilization. By ORPHEUS EVERTS, M. D. Indianapolis: Bowen, Stewart & Co., 1878.

Fifth Annual Report of the Secretary of the State Board of Health of the State of Michigan, for the fiscal year ending September 30, 1877. Lansing: W. S. George & Co., 1878.

Annual Report of the Board of Regents of the Smithsonian Institution, for the year 1877. Washington: Government Printing Office, 1878.

Hepatic Abscess; with some Remarks on Dr. Hammond's Paper. By WALTER COLES, M. D., St. Louis. Reprinted from the *St. Louis Medical and Surgical Journal*, 1878.

A Case of Acute Puerperal Inversion of the Uterus. By JOHN BYRNE, M. D., M. R. C. S. E., etc., etc. Reprinted from the *New York Medical Journal*, 1878.

Batley's Operation; Three Fatal Cases, with some Remarks upon the Indications for the Operation. By GEORGE J. ENGLEMAN, M. D., of St. Louis, Mo. Reprinted from the *American Journal of Obstetrics and Diseases of Women and Children*, 1878.

Books, Pamphlets, &c., Received.

American Gynecological Society, Session of 1877. Report on the Corpus Luteum. By J. C. DALTON, M. D., Boston. Reprinted from the Transactions of the Society, 1878.

Artificial Feeding of Infants, and Description of Instruments and Apparatus of the Author, with Directions for their Use. By A. CLENDINEN, M. D., Newark, N. J. Reprinted from the Transactions of the Medical Society of New Jersey.

Restriction and Prevention of Diphtheria. Document issued by the State Board of Health of Michigan: 1878.

The Relation of Ozone to Disease. Prize Thesis. By J. F. BALDWIN, M. D., Columbus, O. Reprinted from the *Ohio Medical Recorder*, 1878.

On Diet and Hygiene in Diseases of the Skin. By L. DUNCAN BULKLEY, A. M., M. D., etc., etc. Reprinted from the *Virginia Medical Monthly*, 1878.

On the Use of the Solid Rubber Bandage in the treatment of Eczema and Ulcers of the Leg. By L. DUNCAN BULKLEY, A. M., M. D., etc., etc. Reprinted from the *Archives of Dermatology*, 1878.

History of the Medical Society of Oneida County, from its Organization, July, 1806, to July, 1878. By D. G. THOMAS, M. D. Utica, N. Y.: 1878.

Transactions of the Medical and Chirurgical Faculty of the State of Maryland, at its Eighteenth Annual Session. Held at Baltimore, Md., April, 1878. Baltimore: Innes & Co., 1878.

On the Past and Present Treatment of Insanity. By G. F. BODINGTON, M. D., M. R. C. P., Stowbridge. Reprinted from the *British Medical Journal*, 1878.

Restraint in the Treatment of Insanity. By G. F. BODINGTON, M. D., M. R. C. P., Birmingham. Reprinted from the *Birmingham Medical Review*, 1878.

On the Morbid Histology of the Spinal Cord, in five Cases of Insanity. By RINGROSE ATKINS, M. A., M. D., etc., etc., London. Reprinted from the *British Medical Journal*, 1878.

Pathological Illustrations of the Localization of the Motor Functions of the Brain. By RINGROSE ATKINS, M. A., M. D., etc., etc., London. Reprinted from the *British Medical Journal*, 1878.

Journal of Insanity.

Proceedings of the Medical Society of the State of Pennsylvania, in Relation to the Hospital for the Insane at Dirmont. Pittsburgh, Pa.: 1878.

Report of the Care of the Insane. By JOHN CURWEN, M. D. Extracted from the Transactions of the Medical Society of the State of Pennsylvania.

Provision for Insane Criminals. By RICHARD S. DEWEY, M. D. Reprinted from the *Chicago Journal of Nervous and Mental Diseases*, October, 1878.

Bulletin of the Medico-Legal Society of New York. Edited by GEO. W. WELLS, A. M., M. D. New York: published by the Society.

Prognosis in Insanity. By SELDEN H. TALCOTT, A. M., M. D. Reprinted from the *Homœopathic Times*, 1878.

The Nature and Treatment of Inebriety; also the Opium Habit and its Treatment. By Dr. EDWARD C. MANN. New York: Chas. A. Coffin, 1878.

Modern Philosophical Scepticism Examined. By Rev. ROBERT MAIN, M. A., F. R. S. Ninth edition. London: Hardwicke & Bogue, 1878.

Annual Address delivered before the Canada Medical Association, Hamilton, Ont., September, 1878. By JOSEPH WORKMAN, M. D., President.

Mad Poets. By W. A. F. BROWNE. Reprinted from the *Journal of Psychological Medicine*, Vol. iv, Part 2.

Valedictory Address at the Annual Commencement of the University of California, November 7, 1878. By G. A. SHURTLEFF, M. D., Stockton. California: D. H. Berdine, 1878.

The Scientific Lessons of the Mollie Fancher Case. By GEORGE M. BEARD, of New York.

The Watseka Wonder. A Narrative of the Leading Phenomenon in the Case of Mary Lurancy Vennum. By E. W. STEVENS. Chicago: Religio-Philosophical Publishing House, 1878.

In Memoriam. A Tribute to the Memory of Alpheus Benning Crosby, M. D. By his life-long friend, J. WHITNEY BARSTOW, M. D.

Books, Pamphlets, &c., Received.

A Biographical Sketch of Dr. Edvard Warren. Paris: T. SYMONDS, 1878. Reprinted from the *North Carolina Medical Journal* for August, 1878.

Sixty-Seventh Annual Catalogue of Hamilton College, for the year 1878-79. Utica: Ellis H. Roberts & Co., 1878.

Annual Report of the State Hospital for Women and Infants. Philadelphia: J. B. Lippincott & Co., 1878.

Decision Rendered in the Cook Circuit Court, State of Illinois, in the Case of Nathan J. Aiken vs. State Board of Health.

Argument of Plaintiff in the Supreme Court of Michigan in the Case of Edwin H. Van Deusen vs. Nancy J. Newcomer. Kalamazoo: Kalamazoo Publishing Co., 1878.

Report of the Medical Superintendent of the British Guiana Lunatic Asylum, for the year 1877. Demerara: Royal Gazette Office, 1878.

Thirty-Eighth Annual Report of the Crichton Royal Institution. Dumfries: Herald Office, 1878.

Third Annual Report of the Kent County Lunatic Asylum, Canterbury, for 1877. Maidstone: W. S. Virish, 1878.

Fifteenth Annual Report of the Argyll and Bute District Lunatic Asylum. Glasgow: McCorquodale & Co., 1878.

Report of the Committee of Visitors, and of the Medical Superintendent of the West Riding Pauper Lunatic Asylum, for 1877. Wakefield: B. W. Allen, 1878.

Thirty-First Annual Report of the Kent County Lunatic Asylum, Maidstone. Maidstone: W. S. Virish, 1878.

Reports on the Royal Lunatic Asylum of Montrose, for 1878. Montrose: George Walker, 1878.

Twentieth Annual Report of the General Board of Commissioners in Lunacy, for Scotland. Edinburgh: Neill & Co., 1878.

Reports of the Quebec Lunatic Asylum for 1876-77 and 1877-78. Quebec: "Le Canadien" Office, 1877.

Journal of Insanity.

- Report of the Eastern Lunatic Asylum of Virginia for the year ending September 30, 1878.* Richmond: R. E. Fraser, 1878.
- Annual Report of the Commissioners of the State Hospital for the Insane, Warren, Pa.* Harrisburg: Theo. F. Scheffer, 1878.
- First Biennial Report of the Kansas State Lunatic Asylum for the year ending June 30, 1878.* Topeka: Geo. W. Marten, 1878.
- Biennial Report of the Oregon Insane Asylum for 1878.* Salem: Mart. V. Brown, 1878.
- Report of the Visiting Physician to the Oregon Insane Asylum, 1878.* Salem, Oregon: Mart. V. Brown, 1878.
- Report of Senate and House Committee on the Vermont Insane Asylum.* Rutland: Tuttle & Co., 1878.
- Biennial Report of the Commissioner of the Insane of the State of Vermont, for 1877-78.* Rutland: Tuttle & Co., 1878.
- Comments of the Officers of the Vermont Asylum for the Insane, on the Report of the Special Commissioners.* Brattleboro: D. Leonard, 1878.
- Biennial Report of the Officers of the Vermont Asylum for the Insane, for the two years ending July 31, 1878.* Rutland: Tuttle & Co., 1878.
- Annual Report of the Central Kentucky Lunatic Asylum, for 1878.* Frankfort, Ky.: E. H. Porter, 1878.
- Annual Report of the State Lunatic Asylum of Texas, for 1877-78.*
- Report of the Directors and of the Medical Superintendent of the Central Lunatic Asylum (for Colored Insane), Virginia, for the fiscal year 1877-78.* Richmond: 1878.
- Twenty-Third Annual Report of the Trustees of the State Lunatic Asylum at Northampton, for the year ending September 30, 1878.* Boston: 1878.
- Annual Report of the Western Kentucky Lunatic Asylum, for the year 1878.* Frankfort, Ky.: 1878.

Books, Pamphlets, &c., Received.

Eleventh Report of the Directors and Warden of the Kansas State Penitentiary to the Governor of Kansas for 1877 and 1878.

Annual Report of the Secretary of the Treasury on the State of the Finances for the year 1878.

Ueber die Lehre Von der Entwicklung der Ganglien des Sympathicus. Von Prof. Schenk und Dr. W. R. Birdsall, aus New York. (Separat Abdruck aus den Mittheilungen des Embryol Institutes, III.)

ANNOUNCEMENT.

The ANNUAL MEDICAL DIRECTORY of REGULAR PHYSICIANS
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Five Thousand issued in March of each year, and sent to nearly all the Regular Physicians in the State, and distributed largely through the Northwest.

THE NEXT EDITION of this Directory will appear on the first of March next, conforming to the general plan of the previous issues. In order to make it as useful and as practicable as possible, a review of the medical books and a memoranda from exchange journals for the current year will be given, in this way furnishing much valuable information.

THE LIST OF NAMES will be thoroughly revised and corrected, hoping to be able to give a complete and perfect record of the Regular Physicians of the State in active practice. The time and place of graduation should be furnished.

NON GRADUATES (otherwise reputable) of general and continuous practice, who hold certificates from the State Board of Health, are admissible, but must be so designated.

IT IS EARNESTLY HOPED to have the continuous, active co-operation of the entire profession, and particularly the Secretaries of the local Medical Societies, who are urgently requested to aid by furnishing official lists in their locality, and by keeping us informed in regard to appointments, elections and changes in their organizations and lists of members.

YOUR HEARTY CO-OPERATION and prompt assistance in perfecting the lists for the next edition will be gratefully received and promptly acknowledged.

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